S. HRG. 100-378

FAMILY PLANNING AMENDMENTS OF 1987

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

S. 1366

TO REVISE AND EXTEND THE PROGRAMS OF ASSISTANCE UNDER TITLE X OF THE PUBLIC HEALTH SERVICE ACT

JULY 30, 1987

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FAMILY PLANNING AMENDMENTS OF 1987

THURSDAY, JULY 30, 1987

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 2:05 p.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman) presiding.

Present: Senators Kennedy, Hatch, Metzenbaum, Stafford, Humphrey, and Mikulski.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM presiding pro tempore. The committee will come to order.

This is a hearing on the reauthorization of title X of the Public Health Services Act. This is an important program which makes comprehensive family planning services available to all who desire them.

This program was initially authorized in 1970. It has been funded by Congress since that time. The Congress has not reauthorized title X since 1985. On June 16, Senator Kennedy, 24 other Senators and I introduced S. 1366, a bill to reauthorize title X family planning programs. We introduced this bill to reaffirm our support for family planning programs and to strengthen the existing programs.

I should point out that nine of the cosponsors of S. 1366 are from this committee. It should be clear that a majority of this committee feels very strongly about family planning programs and intends that this bill become law this Congress.

At this point we will place the opening statement of Senator Kennedy, who will be joining us shortly, into the record. And, as other members of the committee arrive we will accord them enough time to make opening statements or place their full statements in the record.

[The opening statement of Senator Kennedy follows:]

STATEMENT OF SENATOR EDWARD M. KENNEDY

The CHAIRMAN. Today's hearing concerns one of the most important items on the agenda of the Labor and Human Resources Committee; the reauthorization of the family planning program, Title X of the Public Health Service Act.

The primary purpose of Title X is to provide services and information to reduce the incidence of unintended pregnancy, to improve maternal health and to reduce abortion.

Time and again since its enactment in 1970, the program has proved its effectiveness. A nationwide system of over 4,500 local clinics provides nearly five million

low-income women (including one and a half million adolescents) with access to family planning primary care services.

Health centers financed through Title X often are the first place that low-income women—especially teenagers—receive medical care. State and local health departments serve 40 percent of these clients; Planned Parenthood organizations serve 27 percent; hospitals serve 13 percent; and other non-profit agencies serve as HMO's, neighborhood health centers, and free clinics serve the remaining 20 percent.

Title X is the single largest source of public funds for these services. It covers 34 percent of the total federal and state expenditures in this area.

In the United States today, it is estimated that approximately 9.5 million low-income women and five million teenagers are at risk of unintended pregnancy. Despite the accomplishments of the Title X program, millions of women are still left out. Only about two thirds of the women eligible for the program are currently being served.

The Title X program also has special relevance to our national problems of infant mortality. A large body of research indicates that the timing of births, adequate intervals between births, and family size are all closely related to maternal and infant health. The Institute of Medicine, in its report, Preventing Low Birthweight (1985), concluded that "family planning services should be an integral part of overall strategies to reduce the incidence of low birthweight in infants." A 1986 report by the National Academy of Sciences on strategies to alleviate the problems of teenage pregnancy and childbearing reached a similar conclusion.

Since its enactment in 1970, Title X has specifically prohibited the use of program funds for abortion. Despite this prohibition, the program has been under unfair attack by organizations which oppose family planning.

The fact that these efforts to dismantle or destroy Title X would inevitably lead to more unintended pregnancies and more abortions.

S. 1366 provides a four year reauthorization of Title X, with modest increases in funding for basic services.

The legislation includes two modest new initiatives designed to address problems of growing public concern. The first would increase the research already being conducted under the auspices of the National Institute of Child Health and Human Development for the development of new and improved methods of contraception in order to reduce the high incidence of unintended pregnancy.

The second initiative would expand the existing authorization for information and education service to permit grants to public and private non-profit organizations for community-based information and education programs, especially for teenagers and parents, to help prevent unintended pregnancy and sexually-transmitted diseases. Title X offers an appropriate vehicle for providing such additional assistance, so that we can enhance the efforts already underway by many state and local governments, school systems, churches, and community organizations to deal with these serious problems.

In this time of fiscal constraints on the Federal Budget, it is especially important for Congress to develop preventive, cost-effective health programs. Over the past seventeen years, Title X has established an effective track record in helping women to plan their pregnancies; it has reduced the number of abortions; and it has significantly improved the national overall record on maternal and child health.

I look forward to the comments of our witnesses today on this important program.

Senator METZENBAUM. Will all the witnesses who will be testifying today come forward and be sworn?

[Senator Metzenbaum administered the oath to witnesses.]

Senator METZENBAUM. You may take your seats and we will call you when it is time to testify.

The first witnesses on our schedule are Dr. Harry Jonas, who is the immediate past president of the American College of Obstetricians and Gynecologists; and Dr. Richard Narkewicz, who is the president-elect of the American Academy of Pediatrics.

Gentlemen, we are happy to have you with us and we will hear from each of you. I think you understand the committee's rules, and that is a 5-minute time limit. We will put your entire statements into the record.

Which one is to go first? Have you agreed among yourselves?

STATEMENTS OF HARRY S. JONAS, IMMEDIATE PAST PRESIDENT, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, WASHINGTON, DC; AND RICHARD M. NARKEWICZ, PRESIDENT-ELECT, AMERICAN ACADEMY OF PEDIATRICS, BURLINGTON, VT

Dr. JONAS. I believe I will, Senator.

Senator Metzenbaum, I appreciate the opportunity to appear before you to discuss why we think it is so important to speak out clearly in support of family planning as a national priority.

S. 1366 is of vital importance to our nation and to the women we serve. The problem of unintended pregnancy in the United States, particularly in adolescence, is a national disgrace. We have the highest rate of teenage pregnancy in the developed world.

Our organization, the American College, launched a nationwide program to educate the public about modern family planning techniques. We started this program as a result of a Gallup poll we conducted which revealed an astonishingly high amount of misinformation among young people about contraceptives.

Young people want more information about pregnancy prevention. When are we going to reach a level of maturity in this country so that the word "contraceptive" is no longer considered a dirty or an unspeakable word?

Ideally, family planning should not be a political issue, and yet without governmental assistance there could be no program for those most in need. This is a social, economic, and health issue which demands good and rational leadership.

If we can achieve our goal of reducing unintended pregnancy, we also would substantially reduce the need for abortion in this country. Even though unanimity on the question of whether abortion should be legal, lightly or tightly restricted, or abolished is perhaps unattainable, can we not find broad agreement on the desirability of reducing the need for abortion? Can we not unite constructive forces in efforts to promote sexual responsibility among both young men and young women?

Today, we are actively involved in programs to promote more responsibility in areas of individual human behavior. We should and we do encourage young people to say no to drugs, to say no to sexual activity, even to say no to smoking.

But only saying no to everything is not enough. We must promote efforts toward more comprehensive and more effective ways to ensure responsibility. Good family planning education, accessible family planning services, and safe contraceptive techniques are the foundation of any national program of responsible family planning.

Title X must remain as the keystone of that foundation. Family planning services should be equally provided on a national level, not fragmented by the whims of 50 different States.

Let me acknowledge that there may be disagreements over this program. Some individuals are opposed to all forms of contraception except natural family planning. Some may argue that access to contraceptives increases the rate of sexual activity among teenagers.

I have spent a lifetime of involvement in providing reproductive health services to women of all ages. The adolescent patient pre-

sents a special challenge to physicians and other health care personnel.

These young people do not come for contraceptive services just so that they can be more sexually active. In my opinion, the young people who come seeking contraceptive services are responsible young adults who are not yet ready to undertake full family responsibilities.

We must avoid imposing a guilt trip on these biologically mature young people. We should commend them for being responsible. We should respect their desire for confidentiality in seeking these services.

I can tell you that as a practicing physician who treated many young women who come to me for family planning advice, if I had rejected their involvement in sexual activity, if I had demanded parental notification before prescribing contraceptives, I am certain that I would have driven many of them away, with the resulting consequences of more unintended pregnancies and more abortions.

In my counseling efforts, I always stress the importance of the consequences of sexual activity, as well as unprotected sexual activity. Many times, these young women went home, voluntarily discussed the situation with their mothers, and returned with their parent, who oftentimes supported their daughter's decision.

Keep in mind, however, that we do not live in a perfect society where every adolescent is part of an intact family, and many of these young women have no parents they can turn to for either advice or support. Therefore, our organization opposes any form of mandatory parental notification or consent.

All patients have the right to decide what medical care they wish to receive. Patients can make this choice only after being fully informed by the health care provider of the risks and benefits of the various options. These include continuing the pregnancy to term and keeping the infant, adoption, or abortion.

Our Nation was conceived and designed by human beings like ourselves, imperfect as we are all imperfect.

Senator METZENBAUM. Dr. Jonas, can you wrap up?

Dr. JONAS. But a nation which believes in and cares about its young people is essential and we must remain committed to the release of human potential and the liberation of the human spirit.

It cannot be wrong to help people cope more intelligently with their sexuality. It cannot be wrong to prevent children from having children. It cannot be wrong to reduce the need for abortion.

I challenge you as our Nation's leaders to make a choice for reason, to support this important program. Do not disable it, do not tinker with it, do not dismantle it.

Thank you.

[The prepared statement of Dr. Jonas follows:]

STATEMENT

of

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

on

REAUTHORIZATION OF THE TITLE X FAMILY PLANNING PROGRAM

Presented by

Harry S Jonas, M.D., FACOG

before the

Committee on Labor and Human Resources

U.S. Senate

July 30, 1987

Mr. Chairman, Members of the Committee, I am Harry S Jonas, M.D., FACOG, Immediate Past-President of the American College of Obstetricians and Gynecologists (ACOG), an organization of more than 26,000 physicians specializing in the delivery of health care to women. I appreciate this opportunity to appear before you to discuss the reauthorization of Title X and the related issue of the appropriate federal role in supporting family planning services and population research. My comments will focus on the benefits of family planning services, especially to teenagers, counseling regarding options, and the contraceptive initiative included in the reauthorization measure.

BENEFITS OF FAMILY PLANNING

Title X of the Public Health Service Act provides voluntary family planning services to nearly 5 million women annually to help them avoid unintended pregnancy. Most women can become pregnant from the time they are teenagers until they are in their late 40s or in some instances, their early 50s. This means that for 30 to 40 years of the normal woman's average lifetime she may become pregnant. Research shows that birth spacing, appropriate timing between pregnancies, and limitation on family size, as a result of the use of contraceptives, are closely related to improved infant and maternal health.

A reduction in infant mortality and low birthweight, a leading cause of infant mortality, has been correlated with effective family planning. The relationship between low birthweight and infant mortality is well-documented in the report Preventing Low Birthweight issued by the Institute of Medicine (IOM) in 1985. Infants weighing 3,000 to 3,500 grams, or 6.6 to 7.8 pounds, experience the lowest mortality rates. The mortality rate increases rapidly with decreasing birthweight for those infants who weigh 2,500 grams (5.5 pounds) or less. Most infants die who weigh 1,000 grams (2.2 pounds) or less. The majority of these infant deaths occur within the neonatal period, that is, the first month of life.

In addition to increasing the rate of infant mortality, low birthweight also increases the rate of morbidity in infants. Several health problems that have been associated with low birthweight include abnormalities with neurological development such as cerebral palsy and an increased risk of developing respiratory tract conditions.

Several risk factors have been identified which contribute to low birthweight. These include some chronic illnesses, smoking, moderate to heavy alcohol use and drug abuse, poor nutritional status, and susceptibility to infectious agents such as rubella. Other risk factors include childbearing at an early age or late age (under 17 or over 34), a brief period of time between pregnancies, and a large number of births. It is possible for the health care provider to identify many of the risks associated with low birthweight in a woman before she becomes pregnant. Many of these risks can be reduced through appropriate education. In particular, the risk factors associated with timing and number of births can be reduced by effective family planning which can either prevent pregnancy or time the occurrence of a pregnancy. The authors of the IOM report recommended that "family planning services should be an integral part of overall strategies to reduce the incidence of low birthweight in infants." The need to educate women and teenagers about human reproduction and the risk factors which contribute to infant mortality is also identified in the IOM report.

Several research studies indicate that there is an unmet need in this country for contraceptive services especially among teenagers and low-income women. Authors of the IOM report recommended federal subsidization of family planning, through programs such as Title X, to meet this need. The ACOG agrees that the Title X program is well-designed to target low-income women and teenagers, populations that are at high risk for poor pregnancy outcome.

In addition to reducing risk factors associated with low birthweight and infant mortality through the provision of family planning services, Title X clinics provide other beneficial health services to women and teenagers. These include preventive health measures such as screening for cervical cancer and sexually transmitted diseases. Such diseases may not be diagnosed if the patient does not visit a Title X clinic for contraceptive services.

SERVICES TO TEENS

The ACOG is especially concerned with the special health needs and health problems associated with sexually active adolescents. The United States has the highest rate of teenage pregnancy in the developed world. Each year, more than one million teenagers become pregnant. The National Institute of Child Health and Human Development (NICHD) recently reported an alarming shift toward more births among younger teenagers, those 12 to 15 years old. If this trend continues, 40 percent of current 14 year olds will become pregnant before reaching the age of 20 and one in five will bear a child. As noted in the IOM report, the rate of maternal mortality and morbidity and the risk of giving birth to a low birthweight infant are considerably higher among teenage mothers. The available evidence shows that infants of teenage parents are much more likely to be of low birthweight and to die than are those born to mothers over the age of 20.

In addition to medical problems, teenage pregnancy and childbearing are associated with several social and economic issues. Most adolescents are ill-prepared emotionally, physically, or financially for the responsibilities of parenthood. The Center for Population Options recently reported that the United States spent $18 billion in 1986 in public assistance payments to households where the mother was a teenager when her first child was born. Both the personal and the public costs of early childbearing stretch across decades and generations.

The ACOG recently initiated a nationwide program to help reduce the incidence of unintended pregnancies. This program consists of a series of public service announcements, which are being aired by the major television networks, their affiliates, and cable stations, to educate the public about the safety and effectiveness of modern contraception. The campaign features a toll-free telephone number, 1-800-INTENDS, which anyone can call to request a pamphlet that includes facts on all contraceptive methods. The pamphlet also conveys the message that it is okay to say no to sexual activity. Since the program was implemented in July 1985, 125,000 calls have been received and more than 200,000 pamphlets have been distributed.

Although ACOG urges teenagers to postpone sexual activity, 2.4 million teenagers under the age of 18 are at risk of pregnancy because they are sexually active. Statistics clearly indicate an adolescent population that is more sexually active at an early age and increasingly less inclined to use the most effective forms of contraception. During the 1970s premarital sexual activity among young women 15 to 19 years of age increased by 67 percent. Today, six of every ten teenage women are sexually active by the age of 19, and four of every ten are sexually active by the age of 17.

Some argue that access to contraceptives increases the rate of sexual activity among teenagers. This is simply not true. Female adolescents generally wait approximately six months to one year after the initiation of sexual activity to seek medical advice. This is often to request a pregnancy test. More than 85 percent of teenagers first visiting family planning clinics are already sexually active, and 50 percent have been so for nine months or more. Research indicates that fifty percent of all teenagers do not use contraceptives during their first sexual experience. Twenty percent of first pregnancies occur in the first month after the initiation of sexual activity. Fifty percent occur during the first six months.

Abortion is more prevalent in teenagers than in other populations. Of the one million adolescents who become pregnant each year, more than half of these young women give birth. The other half terminate their pregnancies. Adolescent women whose first pregnancy ends in abortion usually practice contraception more vigilantly thereafter and are only half as likely to become pregnant again within a year than are those whose first pregnancy ended in a live birth. Clearly, the availability and effective use of contraception, particularly among teenagers, is the most effective way to prevent unintended pregnancy and thereby reduce the need for abortion.

The authors of the recently published National Academy of Sciences' report, Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing, also conclude that "the most effective intervention for reducing early unintended pregnancy in sexually active teenagers is diligent contraceptive use." The report recommends continued public support for the provision of contraceptive services to adolescents and cited Title X as one important example of such a program. Title X clinics can play an important role in education and outreach to the teenage population.

The ACOG encourages obstetrician-gynecologists to provide health care services to the sexually active female during her teenage years as they would any patient, regardless of age or emancipation status. Our organization recommends that sexually active teenagers of any age, and all those aged 18 years or over, should be encouraged to have yearly pelvic examinations. The sixth edition of ACOG's Standards for Obstetric-Gynecologic Services states: "The sexually active adolescent female deserves special attention because of the high incidence of unintended pregnancy in this population. The gynecologist should attempt to ensure that individuals exposed to the risk of unwanted pregnancy have access to the most suitable methods of contraception."

Studies indicate that one of the major causes for delay by adolescents in seeking contraception is fear of parental discovery. Our organization urges health care providers who work with adolescents to encourage family involvement when feasible. The ACOG is opposed to mandatory parental notification or consent.

The health care provider's primary duty is to the patient. Adolescents should not be denied care and services on the basis of mandated parental consultation. Mandated parental notification or consent may subject the patient to family friction or abusive behavior. Those teenagers who do not wish to involve their parents will not seek contraceptive services, thereby serving only to increase the rate of teenage pregnancy and ultimately the number of abortions. During the debate on the parental notification rule issued by the Department of Health and Human Services in 1982 and overturned by the District of Columbia Court of Appeals, several clinics reported a drop in the number of teenage patients.

Mandatory parental notification or consent also violates the confidentiality of the patient/physician relationship. The argument has been made that parents should be notified because of the health risks of prescription contraceptives. However, the health risks of pregnancy far exceed the health risks of effective contraception, especially among adolescents. For example, a sexually active adolescent is five times more likely to die of pregnancy-related causes than when using oral contraceptives. For these reasons, ACOG urges the Committee to oppose mandatory parental notification or consent requirements.

OPTIONS COUNSELING

In recent years, there have been several attempts to prohibit the counseling and referral for abortion services in programs receiving federal family planning funds. As federal

funding of abortion is already prohibited by law, such attempts go beyond this restriction and are aimed at restricting the flow of information between a patient and her physician. A prohibition on the content of counseling between the patient and her physician is contrary to medical standards and severely erodes the patient's right to informed consent. As a physician, I respect and value my responsibility to counsel women fully regarding their choices and options of medical treatment.

Good health practice demands open communication between health care professionals and their patients. When we are prevented from communicating adequately and fully with those we serve, patients do not receive the best health care. All patients have the right to decide what medical care they wish to receive. Patients can make this choice only after being fully informed by the health care provider of the risks and benefits of all available options.

The sixth edition of ACOG's Standards for Obstetric-Gynecologic Services states: "In the event of an unwanted pregnancy, the physician should counsel the patient about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offering the infant for legal adoption, or aborting the pregnancy." These standards are consistent with the current program guidelines for Title X. We urge the Committee to oppose any amendments which would restrict the content of counseling between a patient and her health care provider.

CONTRACEPTIVE RESEARCH

Included in the Title X reauthorization measure is a $10 million initiative on contraceptive research. Any funds appropriated under Title X for this initiative are designed to be in addition to those funds appropriated to NICHD for contraceptive research and development.

The need for safer and more effective methods of contraception is more important than ever and ACOG urges the Committee to support this initiative.

Women today have fewer contraceptive choices than were available only one year ago, in large part due to the current product liability climate. This climate has affected the availability of contraceptives on the market as well as technological innovation in this area. In 1986, the G.D. Searle Company withdrew the Copper-7 IUD, used by over two million women in the United States, from the market. Prior to 1986, several other IUDs were also withdrawn. Searle's decision to remove the Copper-7 from the market was reached because of the high costs of defending liability suits and the inability to obtain adequate insurance, despite continued Food and Drug Administration (FDA) approval of the product.

Recently the Supreme Court refused to review and thereby let stand a lower court decision in Ortho v. Wells, which awarded $4.6 million in damages against the Ortho Pharmaceutical Company. The suit was filed by a woman who became pregnant while using contraceptive jelly and later claimed that it caused severe birth defects in her infant. The decision in this case is particularly disturbing because it contraindicates available scientific evidence. It is of great concern that pharmaceutical manufacturers of spermicides may withdraw such products from the market if they are faced with the costs of defending additional suits involving huge awards. This would have a devastating effect on contraceptive availability of the spermicide nonoxynol-9, which is used in several birth control methods, including foams, creams, alone or with the diaphragm, and with the contraceptive sponge.

The liability crisis has also affected technological innovation. Traditionally, contraceptive research and development have been carried out by the pharmaceutical industry, the federal

government, and non-profit organizations. Several manufacturers are no longer carrying out research and development due to the specter of liability suits, low return on their investments, and the long FDA approval process. These same factors also hamper small firms from carrying out innovative studies. Research in this area now falls almost exclusively to the federal government and non-profit organizations. The ACOG commends the Chairman for recognizing the need for additional contraceptive research and development to assure that American women have access to the safest and most effective contraceptive methods.

CONCLUSION

In conclusion, ACOG supports prompt reauthorization of the Title X family planning program. We urge the Committee to recognize the special needs of adolescents. We also urge the Committee to maintain the medical integrity of the program and to oppose any amendments requiring parental notification or consent or restricting the content of counseling between the health care provider and patient.

I will be happy to answer any questions.

Senator METZENBAUM. You have taught Senator Hatch and me, who pride ourselves on our filibusters, how to filibuster the committee and not be cut off.

Senator Hatch is with us and Senator Stafford is with us. We appreciate your comments, Dr. Jonas, and they were very helpful to us.

Dr. Narkewicz, I am going to ask you to yield to Senator Hatch. He is a member of the Iran-Contra Committee and must go back to it, and I think he has an opening statement.

Senator Hatch.

OPENING STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you, Mr. Chairman.

Dr. Jonas and Dr. Narkewicz, I welcome both of you to the committee, of course, and all of our other witnesses, to this very important hearing. Today, we discuss one of the most sensitive issues facing Congress—how to provide family planning services to low-income women.

Since the enactment of title X in 1972, Congress has been deluged with debate over this particular program, and following the addition of teenagers to those who can get services under title X under this program, we have added fuel to the fire by raising the issue of parental rights versus patient confidentiality.

It seems to me that there are no easy answers and no single solution which addresses all the differing needs confronting this program. It remains apparent that individual citizens through their States must have the right to provide family planning services in a way they feel is best.

Many of the members are aware of the unique situation in my home State of Utah. In 1981, the Utah State Legislature enacted a law requiring parental consent if a teenager was prescribed prescription drugs or devices paid for with federal funds.

Subsequently, the 10th Circuit Court of Appeals invalidated this State statute, arguing that it was not the intent of Congress to require consent when providing prescription contraceptives to minors.

The appellate court's decision was costly for Utah, and certainly for our State family planning services sponsored through the Utah Department of Health, because we were required to forfeit all Federal funding and non-governmental clinics became the only legitimate grantees under the title X Program.

The Utah State Legislature debated on two separate occasions whether to overturn this law and they declined to do so, in spite of the revocation of funds. As policymakers in the State, they believe that family planning programs that give prescription contraceptives to teenagers must involve parents.

They feel parental involvement is an excellent way to reduce teenage pregnancy, a sentiment which I might note is shared by Eunice Kennedy Shriver, executive vice president of the Joseph P. Kennedy Foundation.

Many Utah legislators point to the fact that teenage pregnancy rates in Utah declined during the period in which this State law was in effect. Since 1984, I have been informed by the Utah State

Department of Health, that some women in Utah are not able to receive necessary family planning services, given the existing funding limitations. These women are predominantly located in rural areas.

The health department, of course, has asked me to do all I can to help the State once again receive title X family planning funds. Now, last year when we addressed this issue, the committee voted unanimously to include a demonstration authority to test the effectiveness of the Utah law.

Although the bill was not considered by the full Senate before adjournment, it represented an equitable compromise to the dilemma facing my home State of Utah, and it only applied to my State.

Now, I have been told that Planned Parenthood has been lobbying extremely hard to pressure this committee against our agreed-upon Utah waiver. It was unanimously agreed upon. I expect that commitment to be kept because I think we are in a unique situation. We may learn from this situation whether or not the Utah law actually will lead to a reduction in teenage pregnancies elsewhere as it has in Utah.

I am disappointed with the position of Planned Parenthood because I, for one, believe we should consider and test all possible ways to reduce the number of teenage pregnancies. If the Utah State Legislature is right, we should not prevent their success. No one person or organization has a lock on the answer to this.

Now, I might also add that if we are right, then it may be something that other people in many other States may be interested in. If we are wrong, I will be the first to repeal this provision in this statute, but at least we ought to be given the chance.

It is one out of 50 States, it is unique. The legislature stood solidly behind it and I think we have statistics to prove that it works, but over a period of time we will know.

Now, I have to throw a warning out here that I expect my colleagues on this committee to live up to that commitment to me. I make and kept my commitment to them and I intend to do that this year, but they should keep their commitment to me. If they do not, then this is going to be one battle. We are not going to dictate to individual States what they can and cannot do because of one organization in this country, albeit an important organization.

I feel that deeply about it. Doctor, I believe you disagree. If you are, I will repeal it. But if you are wrong, you had better find out about it. The only way you will find out about it is if we give this one demonstration project a chance. And if it is right, then I think you will be willing to retract some of the statements you have made, at least I hope so.

Let me make another comment about these hearings. Due to a series of actions taken by some staff members of majority members and others, an impression has been created that this Senator opposes family planning programs.

Now, I would like to point out for the record that I have supported the last three bills reauthorizing title X, so I do not oppose family planning programs. But I hope no one misunderstands my support.

I intend to fight to protect the right of my State, and if any other State feels the same way, but in this one case as one demonstration project, the right of my State to exercise its own policies.

Washington, I have found, does not have all the answers, and the Federal Government's record to date offers no justification to prohibiting the Utah State Legislature from exercising its will in this particular area.

Keep in mind I have made a commitment here. If I find that it really does not work, then as much as I want the Utah State Legislature to have this right, I will work to repeal it.

The Supreme Court may very well uphold the right of States to make these types of determinations, and they may very well do that under the Constitution. But this is an important issue. I think it is an important issue to this committee. If this one demonstration project is included, I will do everything I can to help get family planning funds reauthorized.

Let me just mention, that I am really pleased that my colleagues have invited two Utah witnesses here today, a member of our State legislature, Steve Rees, who will talk further about the role of our State government, and Stan Weed, who has some very interesting sociological statistical work that has been done.

I would also, Mr. Chairman, with your permission, like to insert Senator Helms' and Congressman Kemp's statements for the record immediately following my statement.

Senator METZENBAUM. Without objection, so ordered.

[The prepared statements of Senator Helms and Congressman Kemp follow:]

STATEMENT OF THE HONORABLE JESSE HELMS
JULY 30, 1987

Mr. Chairman, I appreciate the opportunity to testify before this Committee this afternoon. It is not often that I request to appear before my colleagues in this role. And, in light of the additional witnesses who want to be heard, I will be brief.

A few years ago I quoted a statement that one and half billion dollars in the hands of terrorists could not have inflicted the long-term harm to our society that Title X expenditures have. I agreed with that statement then and I agree with it now, and I believe the American people would also if they were told the facts.

For too long, many Senators and Congressmen have been afraid to address the problems in this program for fear of the wrath of Planned Parenthood and the rest of the abortion industry. The facts should be laid on the table. The American people have a right to judge for themselves.

That is why I am here today. There are serious problems with this program, and Congress should have the courage to correct them. The American taxpayers have the right to know that their hard earned dollars are being used by Planned Parenthood and the abortion industry in this country for abortion-related activities which is clearly in violation of the original intent of this legislation; that Title X monies--hard-earned tax dollars--are being used to provide free contraceptives to minors in our communities and in our schools without parental consent; and that the Title X program has failed miserably to curb teen pregnancies and teen abortions and is probably exacerbating the problem.

Let's look at what course this program has taken with respect to maintaining the intended wall of separation between abortion and family planning.

It's obvious that Congress intended a strong wall of separation between abortion and family planning. In explaining Section 1008--the language disqualifying programs from Title X funds if they were involved in abortion--the sponsors were clear:

> "With the 'prohibition of abortion' the committee members clearly intended that abortion is not to be encouraged or promoted in any way through this legislation."

Yet, once passed, the bureaucratic termites--with the pressure of special interest groups--began eating away at this program's purpose and its prohibition on abortion. It was only a matter of time before they had reshaped the Title X program from one which was not intended to be involved in abortion at all to one where millions of dollars are going to subsidize the abortion industry.

Under current policies, Title X recipients can engage in abortion so long as they play the "shell game" and use non-Title X monies to perform abortions. The Title X program can be co-sited with an abortion clinic. Title X funds can and have been used to provide information about abortion services and names and addresses of abortion providers. Title X funds can and have been used to inspect facilities to determine their suitability to provide abortion services. Title X monies can be used to pay dues to organizations that advocate abortion.

In 1982, the General Accounting Office (GAO) investigated this matter and found the following: One clinic provided loans for abortions from nonprogram funds but charged to the Title X program the administrative costs associated with the referral and loans. Another clinic handed out materials which listed various birth control methods with the barrier method and early abortion in the event of failed contraception. Four clinics provided clients brochures prepared by abortion clinics. Several clinics in Indiana provided and witnessed the signing of consent forms required by an abortion clinic.

GAO also discovered that HHS had neither clarified its policy with respect to abortion related activites nor used its regulations and guidelines to communicate to Title X recipients its position on Section 1008. In conclusion, the study recommended that the Secretary establish operational guidance to Title X recipients and incorporate this guidance into Title X program regulations and guidelines.

And what has been done about it, Mr. Chairman? Not one thing. Title X recipients, some of which are up to their eyebrows in abortion activities, continue to carry on their merry way, using Title X dollars to promote abortion and to sustain their baby-killer factories with non-Title X monies.

Even the current leadership at HHS has ignored these abuses and have refused to stop them. One person tried to make changes in this sacred cow; she got fired for her efforts. I'm happy to see that today, the White House has provided the needed leadership on this issue. And I hope that it is the beginning of needed reform.

I find it equally disturbing that over the course of the last decade a large portion of the Title X monies have been used for secret sex programs for our nation's teenagers. I say secret because the bureaucrats have through confidentiality and income eligibility requirements have made sure that parents are left in the dark.

I believe American parents deserve an explanation as to why they must give consent before their child gets her ears pierced, yet, they are not even notified when their child receives contraceptives funded by Title X.

I suppose many in Congress have tolerated these secret sex clinics because the so-called experts had told them--and they believed it--that these kinds of programs were the solution to the teen pregnancy problem.

Well, 16 years and $1.8 billion later, it's obvious that the "experts" were wrong. Just look at the facts. Studies by Zantner and Kantner in 1971, 1976 and 1979 show a near doubling of pregnancies from 1971 to 1979 among

unmarried girls and young women aged 15-19 from 8.5 percent to 16.2 percent, followed by a slight decrease in 1982 to 13.5 per cent.

The Congressional Research Service reports that illegitimate births among this age group have increased from 190,000 in 1970 to 263,000 in 1980. Abortions among this age group have doubled since 1973 from 232,000 to 445,000 in 1980.

In Minnesota, where a 1981 law required parental notification for abortion, the pregnancy, abortion and birth rates among adolescents plummeted. According to a 1985 report by the House Select Committee on Children, Youth and Families, from 1980 to 1983, abortions to Minnesota teens, 15-19, dropped 40 percent. The teen birth rate decreased 23.4 percent and pregnancies decreased 32 per cent.

It's bad enough that the American taxpayer is providing hugh sums of money--$1.7 billion to date--to stock the teen contraceptive armory, but now the Title X cannons are being aimed at America's classrooms. Since Planned Parenthood and other pro-abortion groups have failed in curbing teen pregnancy to date, they have decided that they must get to teens before they become sexually active.

According to a 1986 publication by Centers for Population Options seventeen states have school-based clinic programs providing contraceptives, prescriptions for contraceptives, or referral for contraceptives. There are 53 high school sites and eight junior high school sites. Title X provides 3% of the public funds used by these clinics.

Have they worked in the sense of getting more teens hooked on contraceptives? Yes. Have they reduced teen pregnancy? Absolutely not.

Here are a few examples. In Muskegon Heights, Michigan, Planned Parenthood has set up shop in a local high school. In 1985, Planned Parenthood boasted in an information packet that it had successfully reduced the birth rate in the high school from 13% when the clinic opened to 10.3% three years later. But later in the materials, Planned Parenthood admits, "No significant change in the pregnancy rate."

In Kansas City Kansas--the clinic increased contraceptive use from 50% in 1983 to 63% in 1985, yet, the pregnancy rates remained around 10% in both years, although the proportion who reported that they had had a baby dropped slightly.

And the failure stories go on and on.

Even if leaving parents out in the cold and school-based sex clinics had reduced teen pregnancies, I question the long-term implications of this sort of policy.

For the physical health of our children, is it prudent for us to be pumping them with contraceptives, often powerful drugs? And what about the rising incidence of sexually transmitted diseases among our youth? The most effective methods of protection against pregnancy will not protect our children against sexually transmitted diseases. The statistics show a dramatic increase in the incidence of sexually transmitted diseases among our children. The most

current statistics show that one in seven teenagers has a sexually transmitted disease.

And what about AIDS? There are 148 cases of AIDS among 13-19 year olds. There are 7,686 cases among 20-29 year olds, many of whom probably became infected as teenagers. And these figures will certainly grow as the AIDS virus spreads.

Sexual activity is a significant risk factor for contracting AIDS. Don't we owe it to our children to try our best to make sure that they don't contract AIDS?

The American people have a right to know how each of us stands on contraceptives without parental consent, school-based sex clinics and the subsidizing of the abortion industry with Title X funds. I intend to raise these issues on the Senate floor.

I hope that the Senate Labor Committee will look long and hard at this program before reauthorizing it. The Kennedy bill, quite frankly, does not address the problems I have discussed. The Kennedy bill ignores parental rights, familial responsibility and traditional morality. If passed, it would simply subsidize the abortion industry to a greater degree than ever before. It would spend more money on a program which hasn't worked and will never reduce teen pregnancy, as experience has shown.

If this Committee is really interested in restoring the original intent of this legislation, it should rebuild the intended wall of separation between abortion and contraceptives by prohibiting organizations who are engaged in abortion from receiving Title X funds.

If the Committee is really interested in reducing teen pregnancy, the incidence of sexually transmitted disease and AIDS among our nation's youth, I suggest that we stop applying band-aides to the symptom and start addressing the problem--which incidentally is teen promiscuity, not teen pregnancy. I suggest that we return to parents their right to guide, monitor and control the sexual activities of their children.

And although a lot of people around this town run for the hills when this word comes up--we need to emphasize <u>morality</u>. We need to return to the moral principles upon which this country was founded. We need to teach our children that sex outside of marriage is wrong. We have spent millions of dollars on "Just Say No" campaigns against drugs and alcohol. We should do the same with teen sex.

The time for reform is now. We must end the collaboration between the Title X program and the abortion industry. We must end the raging assault the Title X cannons have levied against our parents and against our children.

TESTIMONY OF REP. JACK KEMP
BEFORE THE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE
JULY 30, 1987

Mr. Chairman and Members of the Committee:

I appreciate this opportunity to submit testimony on Title X of the Public Health Services Act. I am a strong supporter of a continued federal effort to provide family planning services to the poor through Title X. However, I share the belief with many members of the House and Senate -- and the American people -- that abortion is not a method of family planning.

I believe it is urgent for the Committtee and the Congress to examine the issue of whether Title X as it is implemented retains a wall of separation between family planning and abortion, abortion counseling and referral.

As you know, Congress first enacted Title X of the Public Health Services Act in 1970. Congress clearly intended to establish a wall of separation between birth control and abortion. Much of the debate concerned whether Title X would be used for abortion counseling and referral, or strictly for family planning services. To clarify the intent of the family planning legislation, Congressman John Dingell authored a provision of the bill that prohibited federal funding for organizations that include abortion as a method of family planning. He explained the intent of this provision by saying:

> With the "prohibition of abortion" amendment--Title X, section 1008--the committee members clearly intend that

> abortion is not to be encouraged or promoted in any way through this legislation. Programs which include abortion as a method of family planning are not eligible for funds allocated through this act.

Since Title X was passed, the wall of separation issue has been debated repeatedly, and Congress has repeatedly clarified its intent to exclude abortion and abortion referral from family planning. For example, during debates to reauthorize Title X in 1978, our colleague Rep. Robert Dornan sought an amendment which would have clarified the intent of separating family planning from abortion by proscribing funding for any "entity which directly or indirectly provides abortion, abortion counseling, or an abortion referral service." His opposition argued that this amendment was unnecessary: that is, Congress already prohibited funds being used directly or indirectly for abortion and abortion referral or counseling services.

The wall of separation issue was raised again in the 1982 General Accounting Office report on Title X, which stated that restrictions on abortion and lobbying activities in family planning programs need clarification. And most recently, the former Deputy Assistant for Population Affairs, Jo Ann Gasper, risked her job because she sought to investigate whether the intent of Congress was being carried out in programs funded under Title X.

We are compelled to debate the wall of separation issue based on these events. But we should particularly seek to examine and restate our intent for Title X when some in Congress seek to increase dramatically funding for Title X and to expand the use of these funds for school-based clinics which provide contraceptives to young students.

These issues make it imperative for Congress to examine thoroughly and to debate openly our intent of Title X legislation. Congress has a responsibility to ensure that its

laws are implemented fully and fairly within our intended purpose.

Let me reiterate my support for family planning services under Title X. Legitimate family planning services which can be provided include: pregnancy testing; adoption assistance; preventive family planning services, not including abortion; infertility services; treatment for sexually-transmitted diseases; and such other services, not including and not related to abortion, as are necessary to advance the health and welfare of its clients. In the case of a pregnant woman, organizations receiving funds apppropriated under Title X are to provide, or are to secure the provision of, only prenatal care services which include: information concerning fetal development; information concerning paternal responsibility for child support, and concerning availability of Aid to Families with Dependent Children; and other services, not including and not related to abortion, as are necessary to advance the health and welfare of the pregnant woman and her unborn child.

These activities are clearly within the original intent of Title X. They would serve to advance true family planning: prevention of unintended pregnancy. They would preserve Congress commitment on family planning: to keep the federal government out of the abortion business.

Thank you for your consideration.

Senator HATCH. I want to thank you for taking me out of order, Mr. Chairman, and I am sorry to interrupt you, Dr. Narkewicz.

Senator METZENBAUM. Thank you, Senator Hatch.

Senator Stafford, do you have an opening statement?

Senator STAFFORD. Well, thank you, Mr. Chairman. I have no opening statement. I do want to welcome Dr. Narkewicz here, since he is from my State, and he is no stranger to this building, but maybe to this committee. He has appeared in front of the Environment and Public Works Committee as a witness there, and so I am glad to have a second chance to hear him over in this committee.

Senator METZENBAUM. Thank you very much, Senator Hatch and Senator Stafford.

We are very happy to hear from you now, Dr. Narkewicz.

Dr. NARKEWICZ. Mr. Chairman, distinguished Senators, and my own Senator, I am Dr. Dick Narkewicz, a practicing pediatrician from Burlington, VT, and president-elect of the American Academy of Pediatrics.

I represent the academy today in urging the prompt reauthorization of title X family planning programs in S. 1366. My colleague, Dr. Jonas, has just spoken eloquently to the issues of family planning, adolescent pregnancy, and its impact on adolescent health.

The academy shares many of the college's concerns and particularly supports their comments on counseling, referral, and parental notification. Mr. Chairman, as a practicing pediatrician, I find myself often the doctor for the young mother as well as for the newborn child.

Given the time constraint, I will focus my remarks on the importance of the family planning program as it relates to child health; specifically, infant mortality, low birth weight babies, and the link with adolescent pregnancies.

As you are well aware, while we are one of the richest countries in the world, we rank 18th among the industrialized nations with our abysmally high infant mortality rate of 10.8 deaths per 1,000 live births. This means every year 40,000 babies die who might have been saved.

We know low birth weight is one of the major determinants of infant mortality, and a large proportion of these babies come from young mothers who have not had access to adequate prenatal care.

Indeed, the proportion of women receiving less care is much higher than average among blacks, Hispanics, the young, the unmarried, the less educated, and the poor. Young mothers are among those women most in need of comprehensive prenatal care. Yet, they are least likely to receive care early in pregnancy.

In 1984, 200,000 babies were born from mothers without any prenatal care. The number of low birth weight babies to each age group dramatically increases as mother's age decreases.

Twenty-five percent of the infants born to mothers under age 15 are premature, a rate three times that of older women. Babies born to teens represent 20 percent of all low birth weight babies from each year. These babies are 20 times more likely to die than babies born at normal weight. Again, the same risk groups stand out as more likely to have premies—women who are black, Hispanic, young, unmarried, less educated, and poor.

Both the Institute of Medicine and National Academy of Sciences have issued recommendations on ways to address the issue of low birth weight babies, and there is much consistency in their findings.

Both recommended that family planning services be an integral part of the overall strategies to reduce the incidence of low birth weight babies. All of their recommendations underscore the importance of title X family planning programs which help prevent unintended pregnancy as well as provide and refer women to appropriate sources of prenatal care.

Particularly for adolescents, title X clinics are the avenue into which they enter the health care system. I think it is very important that this committee not view title X family planning programs as an isolated effort, separate from all other child health programs, many of which are under the jurisdiction of this committee.

Family planning directly affects access to prenatal care, low birth weight babies, the infant mortality rate, children who are born with disabilities, children who are neglected, and those who incur catastrophic health care costs.

In summary, Mr. Chairman, a large portion of our low birth weight infants in the United States are a result of our alarmingly high teenage pregnancy rate. Many of these same low birth weight infants die and make up a large proportion of deaths that contribute to our abysmally high infant mortality rate, and efforts to provide access to reproductive education and counseling, contraceptive information, and availability to these high-risk groups are important steps in the solution of the problem.

If this effort has attracted so much attention, it may speak more for political agendas rather than the welfare of children.

I thank you, Mr. Chairman.

[The prepared statement of Dr. Narkewicz follows:]

American Academy of Pediatrics

T E S T I M O N Y

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

ON

REAUTHORIZATION OF TITLE X FAMILY PLANNING SERVICES PROGRAM

PRESENTED BY

Richard M. Narkewicz, M.D., F.A.A.P.

July 30, 1987

also representing:

AMBULATORY PEDIATRIC ASSOCIATION

SOCIETY FOR ADOLESCENT MEDICINE

Office of Government Liaison
1331 Pennsylvania Avenue, N.W.
Suite 721 North
Washington, D.C. 20004-1703
202-662-7460 / 800-336-5475

Good afternoon. I am Richard Narkewicz, M.D., a practicing pediatrician from Burlington, Vermont and president elect of the American Academy of Pediatrics. I am pleased to be here today on behalf of the Academy which represents over 32,000 pediatricians dedicated to improving the health of our nation's infants, children and adolescents.

My friend and colleague Dr. Jonas has just spoken eloquently to the issue of family planning and adolescent pregnancy's impact on adolescent health. The Academy shares many of the College's concerns in this regard and particularly supports their comments on counseling, referral and parental notification. As a pediatrician, I am going to focus my remarks on the importance of the family planning program as it relates to child health, notably infant mortality, low birth weight babies, prenatal care and adolescent health care. I hesitate to use the phrase infant mortality this afternoon because I fear that we as a society, having become so accustomed to these terms and numbers, have been lulled into complacency. Nevertheless the facts are clear - if not disturbing and shameful.

While we are one of the richest countries in the world, we rank 18th among the industrialized nations in infant mortality with the abysmally high rate of 10.8 deaths per one thousand live births. This means that every year 40,000 babies die. Yet, their deaths are potentially preventable.

Low birth weight continues to be a major determinant of infant mortality in this country. In 1983, 6.8% of all infants born in the United States - over 247,000 babies, were classified as low birth weight. In that same year, the LBW rate increased from 5.6% to 5.7% for whites and from 12.4% to 12.6% for blacks.

Unfortunately, the proportion of low birth weight babies born in 1983 was only slightly lower than it was 30 years earlier -- 6.8% compared to 7.5% in 1950.

It is also clear that the most effective way to reduce the number of low birth weight babies is to ensure adequate access to prenatal care. Second only to socioeconomic status, the prenatal care a woman receives is the most important determinant of birth outcome. Although the overall low birth weight in 1983 was 6.8%, the rate was 19% among infants born to women with no prenatal care and 7.8% to those whose mothers began prenatal care in the third trimester.

The importance of prenatal care is especially true for adolescents. Young mothers are among those women most in need of comprehensive prenatal care, yet they are the least likely to receive care early in their pregnancy. In the United States 2 out of 3 pregnant teenagers under age 15 and almost half of teens 15-17 do not receive prenatal care in the first three months of pregnancy. In 1983, 21.8% of mothers under age 15 and 11.5 percent of mothers aged 15-19 received late or no prenatal care. Twenty-five percent of infants born to mothers under age 15 are premature -- a rate 3 times that of older women. Although births to teenage mothers were only 14 percent of all American births in 1982, babies born to teens represent 20 percent of all low birth weight infants born each year. These babies are 20 times more likely to die than babies born at normal weight.

These children born to children are at increased risk for other problems. Young maternal age may also be a predictor of sudden infant death, gastrointestinal problems and accidents in infancy. Later in life, children born to teenage mothers are less likely to adapt well to school, are more likely to score lower on I.Q. tests, and are at increased risk for repeating at least one grade in school. Additionally, there is some evidence that children born to

young mothers are at increased risk for neglect, mental retardation, congenital defects, and other handicapping conditions, such as epilepsy.

There are consequences also for the adolescent mother. While early childbearing is associated with some adverse health effects, these seem to be largely a function of socioeconomic rather than biologic factors. In studies where maternal outcomes vary by age, these differences are usually in measures that are sensitive to socioeconomic factors, such as complications of toxemia and iron deficiency anemia.

The pregnant adolescent, who has not yet completed her own development, frequently is subjected to several unfavorable psychosocial hazards. She usually is economically dependent, is forced to interrupt her schooling, and is frequently deserted by the father of her baby. Considering the anger and distress engendered in some families by pregnancy in a young, unmarried daughter, it is apparent that these girls bear a significant social burden. Ideally, the choice of sexual activity should be postponed until a rational and mature decision can be made about the option of parenting, thus improving most of the adverse factors for both the adolescent and mother.

The cost to society of the lack of prenatal care is great. The single largest hospital inpatient service funded by Medicaid is routine newborn deliveries. In fact, Medicaid pays 30 percent of all hospital deliveries to adolescents. In addition, the average total cost of caring for a low birth weight baby in a hospital intensive care unit is close to $30,000. Many of the poor and minority teens who give birth to a low birth weight baby do not have the health insurance to cover the costs of such care.

In contrast, the average cost of a complete prenatal care package is only $600. The Academy found that between two and ten dollars are saved for every dollar

spent on prenatal care. On a broader scale, it is estimated that by providing prenatal and post-partum preventive health care to all low-income women, the federal government could save more than $360 million in current costs for neonatal intensive care and rehospitalization for low birth weight infants, not to mention the incalculable future medical, health, education and social costs incurred by these children.

Despite all that we know, little progress has been made. In 1983, 2/3 of the states surveyed showed an increase from 1981 to 1982 in the percentage of women receiving late or no prenatal care. Black infants are still more than twice as likely as white infants to be born low birth weight and the gap is widening. Moreover, data from 1980-1983 indicate a slowing in the decline of infant mortality in the United States.

This inaction is not due to lack of data or direction. As I am certain this committee is aware, in 1985 the Institute of Medicine (IOM) issued a series of recommendations on ways to reduce the occurrence of low birth weight babies. More recently, the National Academy of Sciences released its report, aptly if not painfully titled, "Risking the Future " on ways to reduce adolescent pregnancy. I do not want to oversimplify the important recommendations of either of these organizations -- but there is consistency in their findings and praise for the importance of family planning programs.

The IOM recommended that additional attention be focused on planning for pregnancy, efforts to include making family planning services easily available with special emphasis on reaching low income women and unmarried teenagers under 18. The importance of the Title X family planning program in accomplishing this objective was specifically emphasized. The IOM also emphasized the need for more access to prenatal care.

Among its recommendations the National Research Council emphasized the need for the nation to develop a coherent policy on adolescent pregnancy and concluded the most effective intervention for reducing unintended pregnancy is contraception. The Council argues that contraceptive services should be provided free or at low cost, and existing public programs such as Title X and Medicaid must continue to support contraceptive care for adolescents, minimizing barriers of cost, convenience and confidentiality. The members of the panel also concluded that minors should be encouraged, but not required, to involve their parents in the decision-making process about abortion, a position which the Academy supports. At the same time it noted that without parents involvement, pregnant teenagers should be provided with full information about the possible risk, benefits and consequences of maternity, abortion, and adoption, as well as appropriate referrals.

All of these recommendations underscore the importance of the Title X family planning programs which help prevent unwanted pregnancy as well as as provide and refer women to appropriate sources of prenatal care. Particularly for adolescents, Title X clinics are the avenue into which they will enter the health care system.

In 1983 almost 5 million women received family planning services through federally supported family planning clinics. The typical client is young, has a low or marginal income and does not yet have children. Family planning agencies offer a variety of services in addition to contraceptive counseling and service. Almost all offer pregnancy testing and counseling and testing for sexually transmitted diseases. Between 40 and 50 percent provide prenatal care, special training for staff working with teenagers, teen outreach, and programs for teenagers and for teenage mothers.

Family planning clinic patients are predominately poor, reflecting the intent of these programs, most of which receive Title X funding, to make services available to disadvantaged women. It is important to underscore that the Title X programs provide services to women who may not be able to obtain care in other settings due to financial barriers. This issue is particularly important for adolescents who have identified cost and confidentiality as the two major impediments to receiving family planning services.

S.1366 introduced by Senator Kennedy, Senator Stafford and others reauthorizes the Title X programs for 4 years with modest but necessary increases. As you are well aware, Title X is the single largest source of public funds for family planning services. It comprises 34 percent of the total federal and state expenditures in this area. There are approximately 9.5 million low-income women and 5 million teenagers at risk for unintended pregnancy. Despite the accomplishments of the Title X program, millions of women go unserved, only about two-thirds of eligible low-income women are currently being served. This slight increase in the program will begin to meet only some of those unmet needs.

The legislation would also increase funds for research through NICHD for the development of new and improved contraceptives to reduce the high incidence of unintended pregnancy. Although more than eight of every ten dollars invested in contraceptive research is expended by the U.S., American women have fewer contraceptive options than do people from other developed countries -- this, despite research that shows contraceptive availability and consistent use are higher where there is a greater selection of birth control methods.

The development of new contraceptives is being throttled by insufficient, unstable funding, as well as the increasing costs of liability insurance for

contraceptive products. Unless this dilemma is resolved, painful controversy is likely to continue. It is essential to develop contraceptive methods with reduced side affects that will be more acceptable and used consistently. Although unintended teenage pregnancy will probably not be eradicated, its reduction will be assisted by widely available contraception that is inexpensive, easily used and effective.

In recent years, there have been several attempts to prohibit the counseling and referral for abortion services in programs receiving federal family planning funds. Since federal funding of abortions is already prohibited by law, such attempts go beyond this restriction and are aimed at restricting the flow of information between a patient and her physician. The Academy concurs with the College that a prohibition on the content of counseling between the patient and her physician is contrary to medical standards and severely erodes the patients right to informed consent -- a fundamental principle of medical practice.

In its formal policy statement regarding pregnancy counseling for the adolescent, the Academy has stressed that physicians should respect the adolescent's legal right to determine her course of care. If disagreement develops over the appropriateness of particular options, the pediatrician has the responsibility for referring that patient to an alternative health care resource where her medical needs can be met. The referring physician retains the responsibility for follow-up of the patient to ensure continued optimal health maintenance.

Restrictions on the content of counseling between physicians and their patients is not only unwarranted government intervention in the practice of medicine, but would seriously jeopardize a patient's right to make a fully informed decision about her own health care. Efforts to limit information about all viable alternatives, efforts which would debilitate the federal family planning program, can

only exacerbate the problem. An informed patient with access to effective prevention is clearly at less risk for an unintended pregnancy.

The Academy opposes also any efforts through this legislation to require mandatory parental consent or notification for minors seeking family planning services. As pediatricians whose primary concern is the physical and mental well-being of the nation's youth, we believe such provisions would be a serious detriment to the adolescent seeking health care.

It must be understood clearly at the outset that the Academy strongly favors and encourages parental involvement in adolescent health care. There is no question that young persons are best served by the advice and guidance of caring parents. However, proposals requiring parental notification would do nothing to promote family participation. Parental involvement and communication cannot be mandated. Nor does routine notification, as an isolated response, constitute encouraging parental involvement.

The Academy also maintains strongly that the provision of prescription contraception to adolescents is not a matter of morality or the furtherance of indiscriminate sex -- it is rather an essential pragmatic response for young persons who already have elected to assume a risk, but who moreover wish maturely to assume responsibility in minimizing it. This in no way diminishes our concern that too many young and developmentally immature adolescents engage in premature sexual intimacy to their psychcosocial and physical detriment. But there is simply no evidence that mandatory parental notification or consent will significantly reduce the number of sexually active adolescents or help them make responsible decisions about their sexual behavior. Rather, only a very small percentage said they would forego sexual activity. Most would resort to less effective, over-the-counter methods.

Most sexually active females wait about six months to one year before seeking family planning services. Arbitrary notification at this point, under these circumstances, would have little constructive impact on an adolescent's sexual behavior if the parents were not already involved. This is not to suggest that parental involvement solicited after an adolescent has initiated sexual activity cannot be helpful. However, in those instances where parents have not been advised and where possibilities for communication exist, individualized timing, flexibility, tact and sensitivity are required for notification to be successful. These issues are perhaps best left initially to the physician and adolescent.

The Committee should also recognize that family planning centers also serve as the entry point for adolescents into the health care system. Although many youth initially come to the centers for family planning services, the center may provide an array of health care services and education. Thus restrictive proposals not only would deter adolescents from family planning services but, for many, would restrict the use of a variety of other health care services.

It is important that this committee not view the Title X family planning programs as an isolated effort -- separate from all other child health programs -- many of which are under the jurisdiction of this committee. Family planning directly affects access to prenatal care, low birth weight babies, the infant mortality rate, children who are born with disabilities, children who are neglected, children who incur catastrophic health care costs and others. Many of us rally around the theme of infant mortality. I remind you that a strong family planning is one important component in the solution to the infant mortality problem.

The Academy strongly supports reauthorization of the Title X family planning program through S.1366. That this program has been the focus of so much controversy speaks more to political agendas than the needs of our nation's children.

Senator METZENBAUM. Thank you very much, Dr. Narkewicz.

I have a few questions that either of you can answer. There are people who view this program in moral terms, but your statements suggest that the issue of family planning is a health issue.

Which groups of our population might have their health improved if they could take advantage of family planning options?

Dr. JONAS. Well, Senator, if I may answer, I do think it is a health issue. It is also a social issue. It is also an economic issue. There is no question that providing family planning services to young people—and I guess the only major exception I would take to Senator Hatch's position about his own State is that we are applying a double standard to poor people and to people who can afford to pay.

People who can afford to pay are not restricted in their access to family planning services. People who cannot pay may be restricted if various kinds of restrictive amendments are adopted.

So I think it is important that the group that economically needs help the most to improve their health so they will have fewer low birth weight babies, so they will have a lower infant mortality, is the group we want to help by this program.

Senator METZENBAUM. Dr. Narkewicz, for some time now title X regulations have required that pregnant women be told about all their legal medical options. Some people want to omit information on pregnancy termination.

As a doctor, can you leave out this option when you counsel a pregnant woman?

Dr. NARKEWICZ. Mr. Chairman, I do not believe we can leave that option out. The practice of medicine does not lend itself very well to legislation, and the principles that guide the physician are ones of fairness and equality.

The physician is trained to give to his or her patient the most comprehensive information that one can. The list of options that we as pediatricians give includes the entire gamut of options, including keeping the infant, forming a support group, whether it be the father, the family, society, putting the infant up for adoption or, finally, abortion.

Senator METZENBAUM. If parental consent is required, would teenagers seek out family planning services? In answering that question, would you also answer what impact would a parental consent requirement have on your ability to deliver comprehensive health care to teenagers?

Dr. NARKEWICZ. The adolescent is a very complex person, as all of you who have been through adolescence know. It is extremely difficult to deal with adolescence with the parents around, number one. They are trying to separate themselves from the parents in their decision.

Oftentimes, they may not have the ability to answer all the questions, but they try very hard. In my personal practice, I find that if the parent has to be involved in difficult situations, it quite often prevents the young adolescent from discussing this information with me.

So I would say for the most part it discourages them from seeking medical help and seeking appropriate information.

Dr. JONAS. Senator, I have tried to point out in my statement that I feel very strongly that whenever you can involve the family in counseling, that is wonderful and desirable, and we make every attempt to do that.

But I also tried to point out that the ideal scenario of an intact family for every adolescent, a parent they can turn to for advice, is not always available. Therefore, why not give the physician the full range of authority to counsel that particular patient?

Senator METZENBAUM. I might say in calling upon Senator Stafford that I am going to excuse myself. The chairman of the Committee is now with us, Senator Kennedy, and after Senator Stafford speaks Senator Kennedy will take over.

Senator STAFFORD. Well, thank you, Mr. Chairman. I simply have a question at this point, and a single one, and I am going to direct it, Dr. Narkewicz, to you, if I may, because it refers to material in your opening statement you did not have time to present to us because of the time limitation.

About how many low-income women and teenagers are at risk for unintended pregnancy at the present time in this country?

Dr. NARKEWICZ. I do not believe I can give the exact answer to that on the numbers, Senator Stafford, but I can certainly insert that in the record afterwards.

Senator STAFFORD. Well, let me refresh your recollection, then.

Dr. NARKEWICZ. It is in my written statement.

Senator STAFFORD. On page 6 of your written statement——

Dr. NARKEWICZ. I do not have a copy real handy.

Senator STAFFORD. I am beginning to sound like the Iran-Contra affair here, am I not?

Dr. NARKEWICZ. I know it. [Laughter.]

Senator STAFFORD. On page 6, you say that there are approximately 9.5 million low-income women and 5 million teenagers at risk for unintended pregnancy, and I assume that that is your statement that I am reading.

Dr. NARKEWICZ. That certainly is my statement, Senator, and I apologize for not having it close at hand.

Senator STAFFORD. Well, I cannot remember what I did last August 16 either. [Laughter.]

I think you go on to say that there are several million women who are going unserved at the present time, and I think that is the point I wanted to bring out.

Dr. NARKEWICZ. That is correct, and about 5 million were served last year.

Senator STAFFORD. Out of the 14.5?

Dr. NARKEWICZ. Out of the 14.5, yes, sir.

Senator STAFFORD. Thank you very much, Doctor. Thank you, Dr. Jonas, and thank you, Mr. Chairman.

The CHAIRMAN. I want to apologize for not being here earlier. We were testifying at another committee. I believe you have answered the principal questions which we had in relationship to your testimony. I think Senator Metzenbaum asked those.

We want to express our appreciation for your presentation. I think we are wise to give weight and thought to those who are dealing with these issues and questions, and we know how constructive you and the organizations which you represent have been

to us in the Congress. So we very much appreciate your presence here. We thank you very much for your testimony.

Dr. JONAS. Thank you, Senator.

The CHAIRMAN. We have the second panel. I would ask them if they would be good enough to come forward. Stanley Weed, Ph.D., director, Institute for Research and Evaluation, Salt Lake City, UT; Jo Ann Gasper, former Deputy Assistant Secretary for Population Affairs, U.S. Department of Health and Human Services, McLean, VA; Richard Glasow, director of education, National Right to Life Committee, Washington; and Steve Rees, State senator from the State of Utah, who is chairman of the Utah Teen Pregnancy Advisory Council, Salt Lake City, UT.

I think Senator Metzenbaum indicated we are going to try and follow the 5-minute rule for the witnesses. Hopefully we will not be interrupted, but I anticipate some interruptions. In order to be fair to all the panelists, we will try and include all the statements in the record and we will leave the record open for members to ask additional questions.

Why don't we start with Stanley Weed?

STATEMENTS OF STANLEY E. WEED, DIRECTOR, INSTITUTE FOR RESEARCH AND EVALUATION, SALT LAKE CITY, UT; JO ANN GASPER, FORMER DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, McLEAN, VA; RICHARD D. GLASOW, DIRECTOR OF EDUCATION, NATIONAL RIGHT TO LIFE COMMITTEE, INC., WASHINGTON, DC; AND STEVE REES, UTAH STATE SENATOR, AND CHAIRMAN, UTAH TEEN PREGNANCY ADVISORY COUNCIL, SALT LAKE CITY, UT

Mr. WEED. Thank you, Mr. Chairman and Senator Stafford. We are delighted to be with you. I am the director of the Institute for Research and Evaluation, a non-profit research corporation which specializes in those social problems and policies relating to adolescents.

My Ph.D. is in the social psychology area from the University of Washington, with special emphasis in research methodology and quantitative methods, data analysis, and applied research. I am pleased to participate in today's hearings and I hope I can contribute to your important deliberations.

The position that I come from with regard to policies and programs is a very practical one, and hopefully similar to that of policymakers and administrators. This position has to do with some basic questions about policies and programs, such as does it work, does it produce the intended result. How do we know? What is the evidence, and how valid and reliable is it? If it does not work, why not, and if it does work, is it cost effective?

These are not questions that are unique to any particular moral position or value system, unless, of course, fiscal responsibility and governmental integrity are unique values. I am assuming they are not and that all of us want to do not only that which is necessary and important, but also that which is effective, even cost effective.

With that context in mind, let me show you what we have learned about family planning programs and their effectiveness

over the past 15 years as it relates to adolescents. On page 1 of my testimony you will see a chart which basically shows the success we have had at influencing and involving teenagers in the family planning programs.

We have moved from about 300,000 teens in 1970 up to 1.5 million teens by 1980, and that has leveled off somewhat since that time period. However, at the same time, we find that the total pregnancy rate for teenagers has increased in a corresponding fashion.

There has been a decline in the adolescent birth rate, but a general increase in the abortion rate, as well as the overall pregnancy rate. With respect to teenage pregnancy, these national figures give us cause for concern. They tell us something about the magnitude of the problem, but they do not tell us if the changes in the national teen pregnancy rate are systematically related to program and policy changes.

Even though we see a change in the pregnancy rate that appears to correspond with the change in the number of clients served, this eyeball correlation does not necessarily prove that family planning is somehow contributing to the increase in teen pregnancy.

In order to make that determination, you need to look at the other factors that influence the teen pregnancy rate, such as mobility, urbanization, social status, race, et cetera.

We have done that, taking into account those variables for all 50 States over a 6-year time period, and the chart that we have on page five of our testimony is a basic summary of the data.

You will notice there—and this is for 1980, although the pattern is similar for all years from our research. In 1980, we did find a reduction in the birth rate. The live birth was down in accordance with family planning involvement for teenagers—about 80 fewer births per thousand teen clients.

However, the overall pregnancy rate was not lower; it was higher. It was in the neighborhood of 40 more pregnancies per 1,000 clients for that year, and for other years it was upwards of 90 more pregnancies per 1,000 clients.

The discrepancy we find is that the abortion rate did not go down like the birth rate did; it went up. So rather than fewer abortions during that time period, we find that there were about 120 more abortions per 1,000 teenage clients in family planning programs. This is not what we expected to find or expected to have happen as a result of implementing the title X program.

Well, in summary, I would say the following: We had thought we were alone—whoops, time is up.

The CHAIRMAN. That is all right. We will ask whoever has the bell if they will just use the lights. [Laughter.]

I do not think my nerves can stand that bell all afternoon.

Conclude.

Mr. WEED. Let me just say in conclusion that this pattern of results was verified in a recent study from the Alan Guttmacher Institute. They found essentially the same pattern; that is that pregnancy rates were either not changed or were higher, the birth rates were lower, and the abortion rates were higher when you take into account all those same control variables that we did.

In our State of Utah, we have found pregnancy rates have gone down in the last 4 years in terms of the parental notification issue, and I can say that we will be getting more information to determine the cause of that reduction. But it is safe to say that we have not seen the pregnancy rates in Utah go up or even maintain their current level, as they have done in other States.

Thank you very much.

[The prepared statement of Mr. Weed follows:]

EFFECTS OF FAMILY PLANNING PROGRAMS ON TEENAGE PREGNANCY

Presented by Stan E. Weed, Ph.D.

INSTITUTE FOR RESEARCH AND EVALUATION

Prepared for

THE SENATE COMMITTEE on

LABOR AND HUMAN RESOURCES

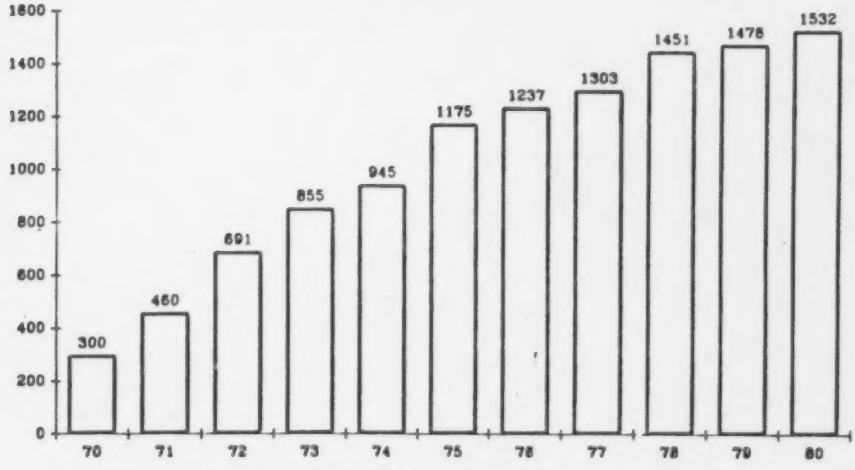
July 30, 1987

EFFECTS OF FAMILY PLANNING PROGRAMS ON TEENAGE PREGNANCY

During the past decade and a half, a major federal attempt to address the problem of teenage pregnancy has consisted of the provision of family planning services to teenagers through some 5,000 family planning clinics throughout the country.

TEENAGE CLIENTS OF ORGANIZED FAMILY PLANNING PROGRAMS 1970 - 1980

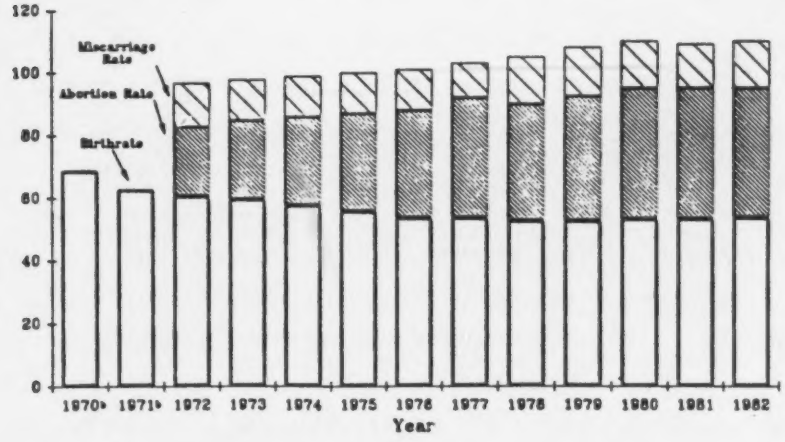
(Clients numbers in 000s)



Source: Allen Guttmacher Institute 1982, Current Functioning and Future Priorities in Family Planning Services Delivery. p.32

Currently, about a million and a half teenagers are involved in these clinic programs each year. During this period, there has been a decline in the adolescent birth rate, but a general increase in the abortion rate as well as the overall pregnancy rate.

Adolescent Pregnancy Rate and Outcomes, 1970 – 1982



a The pregnancy rate is the sum of the birth, abortions and miscarriage rates

b Pregnancy, abortions and miscarriage data are not available before 1972 because abortion was not legal in many areas at that time.

SOURCE: Congressional Budget Office. Pregnancy and abortion data from the Alan Guttmacher Institute, unpublished data. Birth data from National Center for Health Statistics. Advance Report of Final Natality Statistics, 1982, vol. 33, no. 6, Supplement (September 28, 1984), p. 16

With respect to teenage pregnancy, these national figures give us cause for concern and tell us something about the magnitude of the problem, but they do not tell us if the changes in the national teen pregnancy rate are systematically related to program and policy changes. Even though we see a change in the pregnancy rate that appears to correspond with a change in the number of clients served, this "eyeball" correlation does not necessarily mean that these two factors are directly related to each other. For example, some other factor (or factors) may cause these two things to rise or fall simultaneously.

It is essential that the the other things which also affect teenage birth rates (race, poverty, urbanization, mobility, prior fertility, etc.) be taken into account in estimating program effects. Without attention to these other

factors which affect the teenage pregnancy rate, one could not legitimately infer program failure as the pregnancy increases or program success if the rate were to fall. Our research was designed to deal with these and other issues, and to provide an accurate assessment of the effects of family planning programs on teenage pregnancy rates. The fundamental question was relatively simple and straightforward; and addresses a very pragmatic question that policy makers and administrators must ask: "How effective are family planning programs in reducing teenage pregnancy rates? Does increasing the availability and accessibility of contraceptive counseling and services to teens reduce their pregnancy rate as was expected?" This effectiveness question was targeted at the societal level. We approached family planning for teenagers as a social policy or public health issue, which required that we look broadly at data from throughout the country rather than relying on results from a few clinics or a small sample of clients. It was the net societal effect that the policy was aimed at.

Using data from all 50 states and the District of Columbia, we examined program impact throughout the 1970's and early 1980's. This time perspective is important because we needed to ensure that there had been enough time for adequate implementation and reach into the target population. It also permitted replication of the basic findings from year to year, and the use of longitudinal models which could examine changes over time in the pattern of results.

REVIEW OF FINDINGS

With this minimal background, let us review briefly the major findings of the research. The details are available in the technical reports and our time is short, so we will simply try to highlight the main results.

Prior to our research, there didn't appear to be any studies which had directly examined the effects of family planning programs on teenage pregnancy rates. However, there were several which had estimated the impact

of teenage participation in family planning programs on adolescent birth rates. One of the significant efforts looking at the impact on birth rates was done by Dr. Jacqueline Forrest (Alan Guttmacher Institute) and her colleagues and was published in 1981. This study was significant for several reasons:

1. It attempted a comprehensive national assessment of program impact using subunits (counties) in the society of direct interest.
2. It was the first to use age-specific family planning participation rates for teenagers.
3. It used longitudinal as well as cross-sectional analyses.
4. It has served as the basis for estimates of program impact that were widely cited in congressional testimony, as well as in the professional literature and the media.

The study directly estimated program effects on birth rates (for 1975 and 1976), and on the basis of these effects, projections were made concerning the potential effects on overall pregnancy rates. However, since the appropriate abortion figures were not available at the county level, an essential component of the overall teenage pregnancy rate was missing from the study, and therefore a direct estimation of program impact on pregnancy rates was not possible. Additional research was needed to determine the effects on pregnancy rates. Our research and a subsequent study by Susheela Singh (1986) of the Alan Guttmacher Institute have now examined program impact on total pregnancy rates and also on abortion rates.

Pregnancy rates constitute a more appropriate and direct measure of program success than do birth rates, and correspond with the stated intentions and goals of the program--the reduction of unintended pregnancies.

> "If we focus on freedom from unplanned births, then abortion is a means of achieving our goal. If we focus on freedom from unplanned pregnancy, then abortion is a measure of the problem we face. . . The objective of the service program is best measured in terms of preventing unplanned pregnancies, not just unplanned births." (Tyler, 1982:221-223)

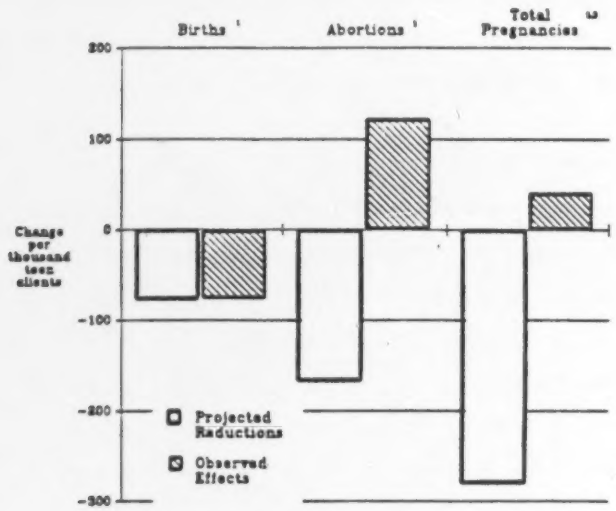
Our studies and the 1986 AGI report provide important new information and

significant corroboration concerning the effects of family planning programs for teenagers on adolescent pregnancy, abortion, and birth rates.

If we compare our results for 1980 birth rates with the projections for that year, we see substantial agreement. Data for other years and other statistical models confirm the same basic finding: where family planning program involvement is greater, one can expect to see lower teenage birth rates. The finding is robust and stable and is found in the 1981 and 1986 AGI studies, as well as our own. The size of that effect is about 80 fewer births for every 1000 teenage clients in organized family planning programs.

IMPACT OF TEENAGE FAMILY PLANNING PROGRAMS

Projected vs. observed change in Births, Abortions, and Total Pregnancies (per 1,000 teen clients, 1980)



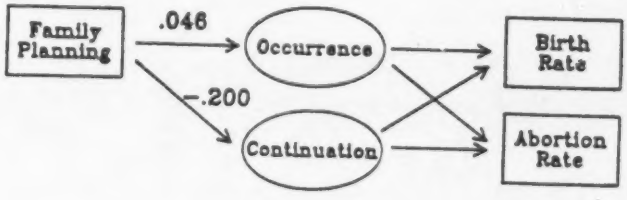
2 Total Pregnancy includes miscarriages, which are estimated at 20% of births and 10% of abortions

1 These represent the remaining effects after accounting for race, poverty, urbanization, and residential stability

Sources: projected reductions (Forrest, 1984)
observed effects (Kost & Olsen, 1986)

However, rather than the projected reduction of 282 total pregnancies for every 1000 clients, we observe an increase of some 42 pregnancies per thousand clients. The main explanation for the discrepancy between the projected reductions and the effects we observed involves the previously unanalyzed relationship between family planning participation and abortion rates. Instead of the projected reduction of some 170 abortions for every 1000 teenage family planning clients, we see about 120 more abortions per thousand clients. Just as we found with birth rates, these findings hold up for the various years, with abortion data from the Centers for Disease Control as well as for the AGI data, and with both longitudinal and cross sectional analyses.

In addition, we analyzed the data in terms of both the occurrence and the resolution of pregnancy. The observed reduction in birth rate was due not to a reduction in the initial occurrence of pregnancy but to a more frequent termination of pregnancy through abortion.



We have also been able to compare our results with those of the recent 1986 AGI study. This is a little difficult from the published reports since their study reports regression coefficients only in standardized form and the values of some coefficients are not reported. Still, where comparisons can be made, the results are very similar, and provide support for our conclusions.

EFFECTS OF TEENAGE FAMILY PLANNING PROGRAM PARTICIPATION ON ADOLESCENT PREGNANCY, BIRTH, AND ABORTION RATES
(STANDARDIZED REGRESSION COEFFICIENTS)

	PREGNANCY	BIRTH	ABORTION
BASIC MODEL			
SINGH	.28	NR	.44
WEED AND OLSEN	.23	-.21	.49
PRIOR FERTILITY CONTROLLED			
SINGH	NR	-.29	.43
WEED AND OLSEN	.24	-.22	.49

NOTE: NR = NOT REPORTED

The negative relationship of family planning involvement with birth rates shown in these studies has been known for some time. However, the positive relationship with abortion and pregnancy rates appears equally consistent across the studies. Although they are new, our own assessment is that these findings are here to stay and have important scientific and public policy implications.

ABORTION AVAILABILITY AND SEXUAL ACTIVITY

As a result of the publication and presentation of these studies, friends, colleagues, and critics have helped us test our thinking and our analyses. We think that the most fundamental question that could be raised about these results is called "model specification" by researchers. This has to do with the kinds of variables included in the analysis, and the relationship these variables have with the outcome of interest (teen pregnancy in this case) and with each other. The basic question is whether including some variable in the model which had previously been omitted might change the observed pattern.

For example, some have suggested that clinics are placed in the high need areas and therefore, one would initially expect to see a positive relationship between family planning and pregnancy until the programs were able to have a detectable impact. However, even after 10 or 12 years, we do not see pregnancy rate reductions. Even when we explicitly control for prior fertility, and use longitudinal models which implicitly control for all stable variables, whether measured or unmeasured, the same results are found.

Some have suggested that including a specific variable, such as abortion availability, non-program sources of family planning services, or sexual activity rates could change the observed positive relationship into the hoped-for negative one. The hypothesis concerning abortion availability was directly tested in the 1986 AGI study. Although abortion availability had an independent effect on the abortion and pregnancy rates, the family planning program effect did not change as a result of including this variable in the model.

With respect to sexual activity, we know that in society generally, teen sexual activity rates have gone up over the years. Some claim that if the analysis controlled for differences in levels of sexual activity, the projected reductions in teenage pregnancy rates would show up. It would help to have the necessary state-level data to test this hypothesis directly. Although we feel that data about sexual activity constitutes a necessary factor in understanding teen pregnancy, there are several basic reasons to believe that this variable would not alter the basic pattern of results found in the recent studies we and AGI have done.

First, neither a general increase in sexual activity nor stable differences among states in levels of sexual activity could account for the observed results. The design of our analysis can discount those possibilities. The changes over time in family planning program involvement would have to have a direct link with corresponding changes in sexual activity

levels. The nature and causal direction of such a link remain to be established.

Second, much of the potential effect of sexual activity on family planning utilization is likely to already be controlled by the variables that have already been included in the models. Just as poverty, race, urbanization, mobility, prior fertility, etc., are strong predictors of teenage pregnancy rates, they also account for much of the variation in sexual activity. Where these and other variables have already been controlled, adding sexual activity is likely to have little effect on model parameters.

Third, the hypothesized effects of sexual activity would have to be extremely large (and inconsistent with other estimates) in order to drastically alter the pattern of our results and fit the prior claims of averted pregnancies. We have estimated what would be necessary to reconcile the previously projected reductions in pregnancy rates with the other information about the effects of sexual activity on family planning utilization and pregnancy among teenagers. This analysis (Weed and Olsen, forthcoming) demonstrates the mathematical and logical inconsistency of the projected teenage pregnancy reductions with the existing data and other information about the effects of sexual activity on clinic use and pregnancy. In summary, including sexual activity when estimating the effect of family planning programs on teenage pregnancy rates may be important and useful, but offers little hope for vindicating the previous projections of pregnancy reductions.

CONCLUSIONS AND RECOMMENDATIONS

What do we conclude about the impact of family planning programs on teenage pregnancy? Our research and that done by others allows us to make four basic statements:

1. Family planning program involvement is related to lower teenage birth rates.

2. Family planning program involvement is associated with higher, not lower, abortion rates among teenagers.

3. Family planning program involvement does not appear to reduce overall teenage pregnancy rates.

4. The reduction in teenage birth rates which can be attributed to family planning program involvement is, in turn, due to its impact on the continuation and not on the occurrence of pregnancy.

What would we recommend in terms of a strategy for successfully dealing with the teenage pregnancy problem? First, we would recommend broadening the options when considering potential interventions. We would have to say that programs which rely on increased accessibility of contraceptive services as the major means of reducing teenage pregnancy are not likely to be effective. Teenage pregnancy is embedded in a complex set of social, psychological, and economic factors that must be taken into account if our efforts are to succeed.

We know more currently about what is not working than why it is not, or what will work. Why has the family planning approach not had the intended impact, and what kinds of interventions will be effective? Our current and future research efforts will focus on both of those latter aspects. We would also recommend more careful and systematic evaluation of program and policy interventions.

> "It is therefore imperative, regardless of which policies are adopted, to evaluate them continuously and carefully in order to be able to change them when and if needed. . . The implemented policies should be evaluated to determine their impact on the incidence of premarital sexual intercourse, use of contraception, unwanted pregnancy, abortion, adoption, and parent-child communication. . . We should not cast our policies and programs in concrete, and should consider changes based on a continuous flow of evaluative information. . ." (Rodman, Lewis, and Griffith, 1984)

Given the drastic consequences of teen pregnancies, sexually transmitted diseases, etc., we can ill afford to go another 15 years assuming that we have an adequate solution in hand.

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The CHAIRMAN. Jo Ann Gasper.

Ms. GASPER. Thank you very much, Mr. Chairman. I am delighted to be here today. I am Jo Ann Gasper. I used to be the Deputy Assistant Secretary for Population Affairs at the Department of Health and Human Services. I would like to make it clear that I am here as an expert witness. I am not representing HHS, or any other executive branch agency for that matter.

I would like to thank you for having my testimony inserted in the record, which I will briefly summarize.

Senator STAFFORD. Mr. Chairman, do you suppose the witness could pull the mike a little closer?

Ms. GASPER. Is this better?

Senator STAFFORD. Yes.

Ms. GASPER. Okay.

When title X was passed and signed into law, it was intended to improve maternal health, reduce infant mortality, and reduce the number of infants slaughtered to abortion. The program has contributed to the reduction of maternal mortality and it has resulted in a reduction in infant mortality once the child is born.

The program, however, has failed miserably by any measure when it comes to stopping the killing of pre-born infants. Yes, the program has helped get pregnant mothers into the hands of the abortionist sooner so that the killing of her child is safer for the mother, but still fatal to the child.

Yes, the program has helped to provide chemicals in order to stop the healthy development of children under the rouse of post-coital contraception. My heavens, the program is tremendously successful in transferring money from the pockets of the American taxpayers to the treasury of that industry which has grown up to assist in the snuffing out of innocent children's lives—an industry that is committed to assisting that babies be denied to their right to life because they happen to be the wrong sex, the wrong race, and maybe not perfect enough or simply just not wanted or mistimed.

In fact, in excess of $30 million each year out of title X is diverted from American family taxpayers and put under the control of organizations such as Planned Parenthood—my, is that not somewhat of a misnomer considering the number of abortions they perform—but organizations that actively promote, advocate and encourage abortion.

I would like to ask is this done because that is what Congress passed and the President signed into law? My heavens, no. The law is very clear. The law states that none of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.

Long-established policy is clear. There must be a clear and distinct separation between the title X national family planning program and abortion or abortion-related activities. Title X is not supposed to promote, encourage, or advocate abortion. Furthermore, abortion is antithetical to the national family planning program.

Contrary to the law, the program has strengthened those who take the lives of children, those children who are most deserving of hospitality, those children yet to be born, and it has happened and happens today because the Department of Health and Human

Services is more concerned about prostituting itself to the abortion industry than in strict enforcement of the law.

The problems are well chronicled in the General Accounting Office report which talks about difficulties in the program in areas such as title X grantees controlling abortion clinics, the use of materials in title X clinics that promote abortion as a backup method of family planning, the paying of dues to organizations that aggressively and actively lobby to encourage and promote and expand abortion in this country, the co-siting of abortion clinics with family planning services so that title X helps to actually underwrite the cost of the submission of children to the abortionist's tools.

On top of the problems found by the General Accounting Office, which I might mention are understated because when the General Accounting Office reviewed the title X program they looked at each individual dollar rather than looking at what is PHS policy regarding the program dollars—on top of the problems which GAO encountered in the clear enforcement of what is the statute and policy, the Department itself has been lax in administering its own rules against funding abortion advocacy organizations.

It has clearly used the English language to permit bureaucratic manipulation of compliance by permitting the funds of programs where abortion is a method of family planning to happen, and yet says it does not.

Those who ask that the Family Planning Program in title X be cleaned up and that the entanglement and taint of abortion be removed from the program are often tagged as anti-family planning and extremist.

But it is those who promote abortion and those who encourage the entanglement of abortion and abortion-related activities with the program who are doing an extreme disservice to the integrity of the title X program.

Title X must be once again returned to what it was originally intended to be, to encourage unmarried children to abstain from premarital sexual relations; to promote, encourage and support adoption; to assist pregnant women to have healthy pregnancies and healthy babies.

Only when title X is purged of all activities and actions which corrupt and poison the program with abortion and abortion-related activities will the national family planning program be what this Congress wants it to be, and only then will the public confidence in the program be restored.

DHHS must not be allowed to be derelict in its responsibilities to Congress and to the American taxpayers, and I am delighted that the President today has, in fact, announced an initiative to bring title X back to compliance with the statute.

Thank you for the opportunity to be here today.

[The prepared statement of Ms. Gasper (with attachments), follows:]

TESTIMONY OF

Jo Ann Gasper

Hearing on Title X of the Public Health Services

Thursday, July 30, 1987

Mr. Chairman, thank you for the opportunity to be here today. I am Jo Ann Gasper, formerly Deputy Assistant Secretary for Population Affairs (DASPA), Public Health Service, U. S. Department of Health and Human Services. I served as the DASPA from February 1985 until July 1987. During that time I was responsible for the administration of the Title X National Family Planning Program and the Title XX Adolescent Family Life program. Both programs are authorized under the Public Health Service Act. I am here today as an individual expert witness. I do not represent the Executive Branch, in particular the Department of Health and Human Services, and my testimony has not been endorsed or reviewed by the Administration.

ABORTION AND ABORTION-RELATED ACTIVITIES

When the National Family Planning Program was originally being debated before the Congress there was a great deal of concern that the provision of family planning services would increase abortion and that the program would encourage and promote abortion. Because of this concern Section 1008 was added to the statute. Section 1008 states:

> None of the funds appropriated under this title shall be used in programs where abortion is a method of

family planning.

Based on that language, the Office of General Counsel (OGC) of the Department of Health and Human Services (HHS) has long maintained in numerous legal opinions that:

- o there must be a clear and distinct separation between the Title X National Family Planning Program and abortion or abortion-related activities;
- o the National Family Planning Program is not to encourage, promote or advocate abortion;
- o abortion is antithetical to the National Family Planning Program.

Unfortunately, the program has never been administered in strict conformity with law and regulation. In 1982 the General Accounting Office issued a report which clearly showed that clarification of restrictions on abortion and abortion-related activities are very much needed. Questionable activities by the grant recipients which the GAO discovered included:

- o A grant recipient was using educational materials which presented barrier methods of contraception together with early abortion in case of failure as a unified method of family planning.[1]

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[1] General Accounting Office (GAO), Restrictions on Abortion and Lobbying Activities in Family Planning Programs Need Clarification, page ii.

- Through interlocking trustees and the exclusive right and power to nominate and elect trustees, a Title X recipient had effective control of a corporation which operated solely to provide first trimester abortions.[2]

- Abortion clients were counted as family planning clients in the HHS reporting system. Since "productivity" was a factor in the awarding of grants and the amount of funds awarded, abortion clients increased the funding to grantees.[3]

- Counseling practices were not consistent with program guidelines. I want to point out that those guidelines, which are still in effect, are inconsistent with the statute and should be changed. However, the GAO found practices which went even farther than those inappropriately permitted by the guidelines. In general these questionable activities consisted in more pervasive abortion counseling than the specific guidelines allow.[4] Abortion counseling that goes beyond the loose guidelines is clearly contrary to the anti-abortion underpinnings of the program.

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[2] GAO, page 7.

[3] GAO, page 9.

[4] GAO, page 16.

- Some clinic practices may have gone beyond "mere referral" for abortion.[5] OGC opinions have stated that "mere referral" for abortion is permitted. However, anything more than "mere referral" runs afoul of the statutory prohibitions on abortion.

- Educational materials presented by family planning clinics presented abortion as a backup if a contraceptive method failed.[6]

- All seven Title X recipients reviewed for lobbying had incurred expenses that raised questions as to adherence with Federal statutory restrictions on use of funds for lobbying.[7]

- Grantees used program expenditures for dues to organizations that lobby at the Federal level. One grantee spent over $27,000. The average expenditure was $8,400 per recipient of Title X funds. The use of Title X funds to pay dues to organizations that lobby for or against pending legislation that would affect the grant program is inappropriate in light of current prohibitions against lobbying and the anti-abortion

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[5] GAO, page 18.

[6] GAO, page 20.

[7] GAO, page 25.

provision within the program's statute.[8]

As serious as were the problems found by the GAO in 1982, the magnitude of those problem was understated. Staff lawyers from the Office of General Counsel advised me that had the GAO reviewed the program expenditures consistent with the Public Health Service (PHS) policies regarding what is considered program funds and therefore bound by program law and regulations, the findings would have been worse.

The GAO erroneously looked at only the direct individual program dollar. Although this is consistent with accounting practice for some HHS programs such as Medicaid, PHS policy is to regard all program dollars as program funds, whether they are direct federal expenditure or are project "match" dollars. Thus, PHS fiscal policy recognizes a federal part in every dollar spent by the "program".

This will be clearer if I give an example:

Medicaid is a reimbursement program. The state incurs expenses and the federal government reimburses the state a specified percentage of the expenditures. The direct dollars received from the federal government are covered by federal law and regulation. The state match dollars are not covered by

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[8] GAO, page 25.

federal law and regulation. Within a Medicaid program 55% of the medicaid program dollars will be covered by federal law and regulation and the remaining 45% of the dollars will be bound by state law and regulation. A state thus may use state medicaid funds for abortion which would not be reimburseable because of federal statutory prohibitions.

In contrast, PHS grant policy dictates that program law and regulations cover 100% of every dollar in a program, including the marching funds provided by the grant recipient.

Because some of the funds which the GAO considered as "private" by their accounting standards are in fact program funds under PHS grants policy, the GAO report understated the degree to which the National Family Planning Program was entangled with abortion, abortion-related and lobbying activities.

Without guidance from DHHS to insure uniform, consistent and strict conformity with the law, the Title X program continues to be riddled with the entanglement of abortion and abortion-related activities in clear violation of law. The administration of the program has not improved since 1982 and the same problems continue and have possibly worsened since the GAO investigation. This is particularly clear as it pertains to the co-siting of abortion and family planning clinics.

CO-SITING OF ABORTION AND FAMILY PLANNING

The co-siting of abortion clinics and Title X family planning clinics is probably the most egregious assault on the integrity of the National Family Planning Program. As the GAO has stated, "the public can get the impression that Federal funds are being improperly used for abortion activities."[9] When the GAO reviewed the Title X program in 1982 the estimate of the number of co-sited clinics was 74. That number has grown to 85 in 1986. What is particularly distressing is that the growth in co-siting is in the type of setting which is most troubling for the credibility of the National Family Planning Program. The co-siting of abortion and family planning by Planned Parenthood grant recipients has grown from 21 to 31. The expansion of co-siting in "other non-profits" has been from 4 to 7.[10] Although the overall growth has been 14.9%, the growth of co-siting among Planned Parenthoods is 47.6%. Other non-profits increased 75%. Hospitals and Public Health clinics showed declines of 2.2% and 33.3% respectively.

Co-siting of free-standing abortion clinics with federal family planning clinics is clearly contrary to the spirit as well as the letter of the law. Furthermore, it undermines the integrity of the National Family Planning Program. A reasonable

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[9] GAO, page i.

[10] See Appendix A: Co-siting.

man or woman quite easily confuses the federal program with the private program tarnishing the reputation of the federal program.

Because of the manner in which the Department has administered the Title X program, this travesty has been permitted to occur and in fact has expanded. Let me give an example of co-siting of an abortion clinic with a family planning clinic.

The facility operates Monday through Friday. The clinics use the same office space and furnishings, use the same clinic personnel, the same receptionist greets all clients and visitors. The only difference is that on Monday, Wednesday, and Friday, all the bills are paid by the federal government and no abortions are performed. Walk through those same doors on Tuesday or Thursday and you have entered an abortion clinic. How is the ordinary citizen to know the difference? The public is not easily able to learn that there are two separate legal corporations. One runs the operations on Monday, Wednesday and Friday. The other corporation is responsible on Tuesday and Thursdays. The husband performs the abortions and is the head of the abortion clinic corporation. His wife is the head of the family planning clinic. All common expenses are pro-rated 60% to Title X and 40% to the abortion clinic because that is the ratio of days of operation. Thus Title X underwrites the expenses of the abortion clinic since such items as medical malpractice, liability and property

damage insurance risks are higher for abortion than for family planning. Furthermore, Title X functions as a marketing tool for the abortion clinic, offering free pregnancy tests and reduced rate services. The family planning program can provide the pregnancy test, the gynecological exam, the "options" counseling, and the referral to the abortion clinic. The woman comes back the next day and has the abortion. She is charged for the cost of the abortion procedure and only the abortion procedure. After the abortion the woman is able to return to the family planning clinic for medical follow-up and any family planning services which she may desire, paid for by Title X.

Did Congress intend this entanglement of abortion with family planning? Is this consistent with the longstanding policy that abortion and family planning must be clearly separate and distinct? The resounding answer to both questions is NO. This kind of activity is not consistent with long established Congressional and ostensible DHHS policy.

The co-siting of abortion services with family planning services within a hospital setting does not result in the same magnitude of problems shown in the example of the co-siting of a free standing abortion clinic with a family planning clinic.

The co-siting of abortion clinics and family planning clinics results in a situation where the abortion services bulk

so large and are so intimately related to the family planning clinic that such a grant is unlawful.[11]

ABORTION ADVOCACY

Approximately 10 years ago, grants management rules were established which pertained to the funding of "Exceptional Organizations". The rules (PHS.i: 1-05) were reissued effective July 1, 1986 as Chapter VII, Part 700--Exceptional Organizations.[12] The purpose of the policy is to ensure that federal funds are awarded to grantee organizations which are competently managed, are responsible, and are committed to

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[11] OGC has stated that:

> It is recognized that in some situations, the abortion element in a program of family planning services may bulk so large and be so intimately related to all aspects of the program as to make it difficult, if not impossible to separate the eligible and non-eligible items of cost. In such a case, we think a grant for the project would be legally questionable.
>
> In other words, a mere technical allocation of funds, attributing Federal dollars to non-abortion activities and other dollars to abortion activities, in what is otherwise a discrete project for providing abortion services, would not, in our opinion, be a legally supportable avoidance of the section 1008 prohibition.

See GAO, pages 13f.

[12] Appendix B has a complete copy of Chapter VII, Part 700 -- Exceptional Organizations.

achieving the objectives of the grants they receive. As defined by the Grants Administration Manual (GAM):

> An organization may be identified as "exceptional" if it advocates a position or course of conduct in the area for which Federal support is sought based on criteria or views that are not germane to, or conflict with, the purposes of the proposed grant. Examples include applications proposing to explore sensitive matters with political, religious, or moral implications. Special precautions, controls, and close monitoring must be stringently utilized in supporting such proposals [emphasis added].[13]

Organizations which advocate, encourage, or promote abortion as a method of family planning or who have actively sought to expand funding for abortion as a method of family planning clearly hold views in conflict with the Title X statute.[14]

There are special risks associated with funding organizations involved in advocacy activities at conflict with the law. Included among the special risks are:

(i) An advocacy organization may be placed in a government-sponsored position of great influence with persons of special vulnerability.

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[13] Grants Administration Manual (GAM) 700.2 Definition (b).

[14] OGC has repeatedly maintained that: 1) the family planning program may not be used to promote, encourage, or advocate abortion, 2) there must be a clear and distinct separation between abortion and family planning, and 3) abortion is antithetical to the family planning program.

(ii) A cause which conflicts with the purpose of the grant may be facilitated and given special strength.

(iii) Personnel choices may be made for reasons foreign to the purpose of the grant.

(iv) There may be special motivations to misjudge defaults or deficiencies of participants or to provide special benefits to employees or beneficiaries.[15]

The GAM Exceptional Organization/Advocacy rules require a grant making official to look not only at what is included within the four corners of the grant application but to look at the organization and its activities -- even if those activities are funded by non-Title X dollars. Under the GAM the awarding agency "shall formally assess the sensitive areas..."[16]

The GAM clearly states that:

> If an organization's commitment to its own goals involves the strong likelihood that grant funds may be misused, or if one of the factors in (b)(1) above result, the option of not awarding the grant should be carefully considered [emphasis in original].[17]

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[15] GAM, 700.7 Advocacy Organizations (b) General Considerations.

[16] GAM, (2).

[17] GAM, (3), page 700-5.

The Department has not enforced these rules. The funding of abortion advocacy organizations clearly falls within the scope of the Exceptional Organization/Advocacy rules. A comparison of abortion referrals shows that Planned Parenthood clinics have a significantly higher abortion referral rate than other types of grantee clinics. The sample examined by the General Accounting Office showed the average public clinic referral rate to be 10.2%, while the comparable figure for the Planned Parenthood clinics was 35.2%. The abortion referral rates at the Planned Parenthood clinics ranged up to 86.4%, while the highest rate of referrals at the sampled public clinics was only 20%.[18]

In fact, rather than attempting to enforce the rules, the department has papered over problems in the program. Members of Congress and the public, when they have expressed concern about the funding of abortion advocacy organizations, have been assured by the department that the "projects" are carefully reviewed. In fact, however, the GAM requires that not only the "project" be reviewed but all the activities of the "organization". The Regional Health Administrators (RHAs) who award the service dollars for the National Family Planning Program have told me that they <u>have not and will not</u> look at the abortion advocacy activities of the organization until they have received explicit written instructions to do so. The RHAs are simply following the

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[18] See comparison of referrals made by Title X recipients, attached.

Department's leadership which has called for the "status quo" in the administration of the National Family Planning Program.

PROGRAM OR PROJECT

Congress prohibited funds going to "programs" where abortion is a method of family planning. The department has administratively interpreted "program" to be synonymous with "project". (A "project" is what is described in the grant application and is typically a part of a larger program conducted by an organization.) Thus, it becomes tautological to say that a family planning program does not pay for abortion as a method of family planning. Programs where abortion is used as a method of family planning simply exclude from their "project" application their abortion activities. DHHS only looks to what is within the grant application and thus will fund the "program" (i.e. project which is part of a large program). The problem of direct conflict with law and Congressional intent, and even DHHS policy, is simply defined away.

A straightforward reading of the statute would indicate that DHHS has contravened the intent of Congress. Section 1008 states:

> None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.

The Conference Report contains the following statement:

> The legislation does not and is not intended to interfere with or limit programs conducted in accordance with State or local laws and regulations which are supported by funds other than those authorized under this legislation.[19]

A strict reading of the statute and its legislative history would prevent Title X funding of those individual programs operated by an organization where convenience or family planning abortions are performed. The organization could operate other programs, which were not supported by Title X, where abortions were performed and not receive funding unlawfully.

DHHS has used the words "project" and "program" interchangeably. This permits DHHS to bureaucratically manipulate compliance.

Program as used within Section 1008 could be read one of three ways:

1) the discrete project described in a grant application
2) the collectivity of several projects or activities into one individual prospectus
3) the totality of the activities or prospectuses of an organization.

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[19] Conference Report, H. Rep. No. 91-1667, December 3, 1970, pages 8f.

The committee report language appears to exclude the third meaning. The second reading of the word "program" is the most common usage of the word and is the most reasonable interpretation of the statute. The definition which DHHS has used is the most distorted, and permits spurious compliance with the statute.

The GAO has stated that Congress may want to provide guidance to HHS if it does not want Title X funds to go to organizations providing abortions.[20] The Administration has introduced legislation which would clarify that organizations which perform or refer for abortions would be ineligible for funds.[21] Passage of this legislation would expand the current statutory prohibitions regarding funding of program where abortion is a method of family planning. The expansion of anti-abortion provisions does not relieve DHHS of the responsibility to administer the current statute in accordance with the intent of Congress. The excuse that DHHS has not followed the law for 15 years simply cannot be permitted to act as an estoppel to strict enforcement of law and regulation.

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[20] GAO, page 11.

[21] S. 1242 introduced by Senator Humphrey and H.R. 1729 introduced by Congressman Hyde.

PROGRAM GUIDELINES ARE AT CONFLICT WITH STATUTE

Although the law and policy are clear, the Title X guidelines are not consistent with law and regulation. Abortion is antithetical to the National Family Planning Program, yet the guidelines require:

- referral for services related to abortion when the mother's life is not endangered if the fetus is carried to term.[22]

- that grantees engage in "options" counseling when a woman has an unintended pregnancy.[23] It should be remembered that there are only two "options" in dealing with pregnancy--one is birth, the other is abortion. To mandate the discussion of family planning abortions is not consistent with law and regulation.

- endorsement of "postcoital contraception", i.e. the administration of drugs to induce an abortion when unprotected intercourse has occurred around the time of ovulation.[24]

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[22] Program Guidelines for Project Grants for Family Planning Services (Program Guidelines), pages 7f.

[23] Program Guidelines, 8.6, page 13.

[24] Program Guidelines, 8.4 Fertility Regulation, page 12.

DHHS did make a commitment in August, 1986 to certain members of Congress to bring two areas of the guidelines into conformity with statute. Consistent with this agreement, modifications to 7.4 Referrals and Follow-up and 8.6 Pregnancy Diagnosis and Counseling were developed and cleared through the Office of General Counsel. The cleared guideline changes were never issued. Guidelines, which had been modified to look like a change had been made, were transmitted to certain members of Congress. However, DHHS refused to officially issue guidelines. The proposed guidelines would have made options counseling permissive rather than mandatory; however, if options counseling were provided, all options would be required to be discussed. Furthermore, the change would have removed any requirement for referral for abortion unless the mother's life were endangered if the fetus were carried to term.

DHHS has maintained that committee report language prevents bringing the guidelines into conformity with law and regulation. But Committee report language is not statute. If it were, Congress would not need the President's signature on any law: It could simply write Committee Reports.

KENNEDY INITIATIVES MISDIRECTED

Legislation introduced by Senator Kennedy (S. 1366) contains

two initiatives which are misdirected and will be counterproductive.

The first of the new initiatives would increase contraceptive research. DHHS currently has an aggressive research agenda to improve contraceptives. There is not a lack of statutory authority for contraceptive research. Furthermore, funding levels are adequate for responsible contraceptive research and development. It is critically important that contraceptive drugs and devices be thoroughly examined and evaluated to insure that the health of women and unborn children not be jeopardized. Research must necessarily move at a pace slower than many would like. The potential damage to women and their children is very obvious. Problems with drugs such as thalidomide and DES, and devices such as the IUD, were not readily apparent. Furthermore, caution needs to be exercised in the development of contraceptives to insure that they are just that -- drugs and devices which prevent pregnancy -- and are not chemical or mechanical methods of destroying innocent unborn children.

The second initiative, to expand contraceptive information and education to children, is also likely to be counterproductive.

Sex education has been available long enough to have

numerous evaluations. Although there is a tremendous variety in what is offered in traditional sex education courses, evaluations of these programs have demonstrated:

- o some increase in knowledge;
- o little impact on values or attitudes;
- o mixed results with respect to contraceptive use;
- o mixed results with respect to pregnancy rates.[25]

Thus, increasing sex education is not likely to result in changes in values or attitudes needed to encourage children to abstain from premarital sexual relations or to effectively utilize contraceptives if sexually active.

What is more promising is abstinence education for adolescents. Most adolescents are not sexually active and it is better to support and encourage children not to engage in premarital sex. Furthermore, sexual activity rates do not have to continue in an upward trend. Although sexually active rates for adolescents 15-19 have risen from 26.8% in 1971 to 42.8% in 1982, sexual activity rates for black adolescents peaked in 1976 at 62.7 and have declined to 57.8% in 1982. This clearly demonstrates that adolescent behavior can change over time. It also demonstrates that the upward trend of adolescent sexual

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[25] Adolescent Pregnancy and Childbearing, Office of Population Affairs, U. S. Department of Health and Human Services.

activity can be reversed.

Increasing contraceptive services and information to children has not been demonstrated to be effective in reducing adolescent pregnancy and abortion rates. Although evaluations of School Based Clinics (SBCs) which provide contraceptives or referral for contraceptives have been done, solid data on them are scarce:

- The primary purpose of providing contraceptive services to sexually active adolescents is to prevent pregnancy. It has not been demonstrated that school based clinics have reduced the adolescent pregnancy rate.

- While some clinics have data which indicate a reduction in adolescent birth rates over time, they do not collect the data necessary to assess the effect of services on pregnancy rates.

- This leaves unanswered the question of whether the decline in birth rates is due to a corresponding decline in pregnancy or an increased reliance on abortion.

- Success is often measured by increased utilization of contraceptive services. This raises the question of

whether these services are being sought by students who are already sexually active or by those who are contemplating initiation of sexual activity because of contraceptive availability.[26]

When contraceptives are provided to children through the schools, the wrong message is being sent to children. It is far better to develop character in schools than provide contraceptives in school. Eunice Kennedy Shriver's approach to preventing adolescent pregnancy through her "Community of Caring" is far more promising than the mechanical pushing of pills. Particularly in the AIDs era, children need to learn that for their health and well-being there is nothing better than one man-one woman-one family.

CONCLUSION

DHHS has not administered the Title X Family Planning Program consistent with law and regulation. The department has consistently ignored the law and its own policies. DHHS has refused to provide even minimal guidance to insure reasonable compliance with Title X's anti-abortion provisions.

One example of mismanagement and inappropriate activity occurred when I was ordered by Dr. Robert Windom, the Assistant

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[26] Adolescent Pregnancy and Childbearing.

Secretary of Health, to violate a department policy against extending lapsed grants. The reason given me why it was correct to extend expired grants was "Frequently, PHS extends budget periods after the expiration of the project period."[27] This is symptomatic of the disregard for strict enforcement of law and regulation, particularly when it pertains to anti-abortion policies.

Those who ask that the National Family Planning Program be cleaned up and the entanglement and taint of abortion be removed from the program are often tagged as being "anti-family planning" and "extremists". But it is those who promote and encourage the entanglement of abortion and abortion-related activities who are doing an extreme disservice to the integrity of the National Family Planning Program. Title X must be enhanced so that it is a program of family planning services which:

- encourages unmarried children to abstain from premarital sexual relations;
- assists sexually active persons to utilize family planning methods of their own choosing (whether natural or artificial methods);
- helps couples desiring children to achieve that goal

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[27] See Shoe, July 1, 1987 memo, attached.

through infertility treatment services;

- o supports adolescents and women with unintended pregnancy in considering adoption;

- o assists pregnant women to have a healthy pregnancy and a healthy baby.

Only when Title X is purged of all activities and actions which corrupt and poison the program with abortion and abortion-related activities will the National Family Planning Program be what Congress enacted and only then will public confidence in the program be restored. DHHS must not be allowed to be derelict in its responsibilities to Congress and the American taxpayers.

COMPARISON OF REFERRALS MADE BY TITLE X RECIPIENTS

Clinic type	Records Reviewed	Abortion Referrals[1]	% Abortion Referral
Public:			
City/County	14	-	-
County	13	2	15.4
County	50	1	2.0
County	50	10	20.0
Other nonprofit:			
Planned Parenthood	50	15	30.0
Planned Parenthood	25	1	4.0
Planned Parenthood	50	5	10.0
Planned Parenthood	50	26	52.0
Planned Parenthood	50	21	42.0
Planned Parenthood	22	19	86.4
University	50	-	-
University[2]	-	-	-
University[3]	-	-	-
Private	50	-	-
Total	474	100	4.74

[Analysis based on data provided in "Summary of Referrals Made by Title X Recipients, GAO, page 19]

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[1] Includes only recorded abortion referrals.

[2] Clinic did not offer pregnancy counseling.

[3] No client files reviewed--clinic did not have current contract with title X grantee.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

Memorandum

Date JUL 1 1987

From Director
Division of Grants and Contracts, ORM/OM

Subject Extension of Title X Nurse Practitioner and General Training Grants

To Chief Counsel, PHS

In accordance with our discussion, it is my understanding that consideration is being given to extending certain Title X Nurse Practitioner and General Training Grants after the expiration of the project periods of these grants.

You have inquired as to the discretion the PHS has to make such extensions subsequent to the expiration of the project period. Frequently, PHS extends budget periods after the expiration of the budget period. In many instances, this occurs after the expiration of the project period. In these cases, the issue date of the award is subsequent to the expiration of the budget or project period. The effective date is always the day after the expired period.

You have also requested advice as to the meaning of the statement contained on page 7 of the PHS Grants Policy Statement that "In no case will such an extension be approved after the expiration date of the final budget period of the project period." This statement applies to extensions requested by grant recipients. A reading of the prior sentence in the Grants Policy Statement makes it clear that the context deals with requests made by grant recipients. The statement does not limit the ability of PHS to initiate and effect noncompeting extensions as contemplated by the preceding paragraph in the Grants Policy Statement which states that "A noncompetitive extension of a budget period or project period may also be initiated by PHS."

Consequently, the administrative policies, including the Grants Policy Statement, which are issued by this office would not preclude the 60-day temporary extensions which you have described to me.

Thomas Shoe

APPENDIX A

GRANTS ADMINISTRATION MANUAL

CHAPTER VII--PHS INTERNAL POLICIES

PART 700--EXCEPTIONAL ORGANIZATIONS

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implements

HHS GRANTS ADMINISTRATION MANUAL

CHAPTER 1-05

TO RECIPIENTS OF PHS FINANCIAL ASSISTANCE AWARDS:

Enclosed is a copy of the reformatted PHS Grants Administration Manual. The Manual has been revised to delete repetitive "boilerplate" language and update terms and references. Part 02, Plan of the Manual, describes the numbering system which is used. Individual chapters are now known as "parts." For those recipients who were familiar with the former numbering system, we have also included at the back of the Manual a conversion table of the old chapter numbers to the new part numbers. Also, at the request of our recipients, we have included an Index of Key Words at the back of the Manual.

The Manual is effective as of July 1, 1986 for all awarding offices and grant recipients. We are making one copy of the revised Manual available to each grantee of record. You are free to reproduce as many additional copies as you need.

Wilford J. Forbush
Deputy Assistant Secretary for Health Operations and
Director, Office of Management

Enclosure

CHAPTER VII - PHS INTERNAL POLICIES

PART 700 - EXCEPTIONAL ORGANIZATIONS

Sec.

700.0 Background and Purpose
700.1 Applicability
700.2 Definition
700.3 Policy
700.4 Identifying Exceptional Organizations
700.5 Minimizing Risk
700.6 Technical Assistance to Exceptional Organizations
700.7 Advocacy Organizations
700.8 Responsibility and Reporting Requirements
700.9 Obtaining Additional Information

700.0 Background and Purpose

(a) PHS policy is to make awards to grantee organizations which are competently managed, are responsible, and are committed to achieving the objectives of the grants they receive. However, experience has shown that a few grantees have performed inadequately with respect to the management and use of PHS grant funds.

(b) This part implements HHS Grants Administration Manual Chapter 1-05, High-Risk Grantees, by providing uniform guidance to PHS awarding offices in identifying "exceptional organizations," as the term is defined herein. This part also provides guidance on actions to be taken once this determination has been reached, and responsibilities for such actions.

700.1 Applicability

This policy applies to all PHS discretionary assistance programs except fellowships or other training awards made by PHS awarding offices directly to individuals.

700.2 Definition

As used in this part, the term "exceptional organization" applies either to an organization which shows evidence of poor business management practices (as explained in paragraph (a) below) or an organization with a sensitive advocacy role (as explained in paragraph (b) below).

(a) An organization may be identified as "exceptional" if it is evident that poor business management practices exist. The existence of such practices may be due to a lack of key management officials (those trained in business management and administration), abrupt personnel changes, a drastic shift in the level of financial operation, or other factors having an adverse effect on the organization. The term may be used in the early review process, or anytime during the life of the project and may be removed once deficiencies have been corrected. Because the term is subjective, each PHS awarding office is required to develop appropriate review criteria for its applications. Once an application is so classified, the awarding office should provide close monitoring and assistance as deemed appropriate by the

Grants Management Officer (GMO). (See section 700.4 and 700.5 for specific identification and notification requirements).

(b) An organization may be identified as "exceptional" if it advocates a position or course of conduct in the area for which Federal support is sought based on criteria or views that are not germane to, or conflict with, the purposes of the proposed grant. Examples include applications proposing to explore sensitive matters with political, religious, or moral implications. Special precautions, controls, and close monitoring must be stringently utilized in supporting such proposals. (See section 700.7 and 700.8 for specific notification requirements.)

700.3 Policy

(a) GMOs and cognizant program officials shall make every effort to identify exceptional organizations before a grant is awarded and during the period of support in accordance with the provisions of this policy.

(b) The award of grants to exceptional organizations shall be reported to the Director, Office of Management (OM), PHS, in accordance with the notification requirements in section 700.5(c)(2). Grants awarded to advocacy organizations shall be reported in accordance with section 700.8(b).

(c) GMOs must ensure that all actions and steps related to this policy are documented and maintained in the official grant file and the institutional file.

700.4 Identifying Exceptional Organizations (Management-Deficient)

(a) General Considerations

(1) No one factor or set of factors alone should be sufficient cause in deciding if an organization is exceptional because of poor management practices, although experience has shown that certain categories of organizations do tend to create situations that are more questionable than others.

(2) Each awarding office must identify exceptional organizations based on carefully developed objective criteria, tempered with judgments of GMOs and cognizant program officials.

(b) Determining Factors

(1) The following factors should be considered in determining if an organization is exceptional on the basis of poor management practices.

(i) Poor financial stability (insolvency or threat of insolvency), or financial dependency on Federal support (i.e., 80% or more of the organization's revenues are expected to be derived from a Federal grant or grants in the forthcoming year).

(ii) Inexperience such as may occur in newly formed organizations or in those which have not previously received Federal grants.

(iii) Serious potential deficiencies in business management systems (e.g., inability to comply with the financial management standards or procurement standards in 45 CFR Part 74).

(iv) A history of unsatisfactory performance, material violations of terms and conditions, or large cost disallowances on previous awards from the same program or other Federal programs.

(c) Useful Information Sources

(1) Information useful in identifying exceptional organizations may be available from several sources, including:

(i) Representations made in the initial grant application, during preaward reviews and site visits, or in the course of negotiating the grant.

(ii) Audit reports issued by the Office of the Inspector General (OIG) Office of Audit, General Accounting Office (GAO), or other Federal agencies, and reports prepared by other auditors, including firms engaged directly by the grantee. (Information on previous audit reports which were issued by the OIG Office of Audit and/or GAO may be obtained by contacting the audit liaison representative in the granting agency or OM/PHS for decentralized programs.)

(iii) Previous experiences with the organization either in the same program, other programs, or programs of other Federal agencies.

(iv) Analysis of the organization's financial statements performed by the Regional Comptroller in conjunction with the indirect cost rate negotiation process.

(v) Evaluation of the organization's financial management capabilities conducted by the GMO or others conducting such evaluation for the GMO. (See Part 611.)

(2) Such sources of information should be sought and evaluated not only prior to award, but also on an annual basis during the life of the grant, since previously satisfactory conditions may change.

700.5 Minimizing Risk (Management-Deficient Organizations)

Options. If it is determined that an organization is exceptional based on any of the factors in section 700.4, the PHS awarding office has four principal options available to minimize the risk.

(a) Not Make the Award. The award should not be made if the nature and extent of the deficiencies are so serious that poor performance is probable and the Government's interests cannot be adequately protected by special conditions, close monitoring, or technical assistance.

(b) Delay the Award. Where there are major deficiencies in the applicant's accounting system or where other deficiencies are known in the business or financial management system, the GMO may delay the award until

such time as the applicant has made the necessary corrections. (See Section 75.61 of 45 CFR Part 74 and part 611 of the Grants Administration Manual.)

(c) Make the Award, But Impose Special Conditions

(1) If the awarding office has determined that a prospective grantee is financially unstable, has a history of poor performance, or has a management system which does not meet the agency's standards, it may impose special conditions more restrictive than those prescribed by 45 CFR Part 74 (see 45 CFR 74.7 and 45 CFR 74.72(e)). When special conditions are imposed, the awarding agency will notify the grantee in writing:

(i) What the special conditions are, why they are imposed, and penalties for noncompliance.

(ii) What corrective action is needed.

(iii) The time frames for satisfying such conditions.

(2) In order to satisfy the reporting requirements prescribed by OMB Circulars A-102 and A-110, the Notice of Grant Award must be amended to show special conditions and a copy must be forwarded immediately to the Director, OM, for transmittal to the Office of the Secretary (OS), HHS. When the special conditions are satisfied and the conditions removed, a copy of the notice to the organization removing the exceptional designation must also be forwarded to the Director, OM, for transmittal to OS.

(d) Make the Award, But Arrange for Appropriate Technical Assistance to the Grantee. This option may utilize the special conditions discussed in paragraph (c) above, combined with arranging for appropriate technical assistance.

700.6 Technical Assistance to Exceptional Organizations (Management-Deficient)

(a) In order to raise the level of the grantee's business management practices, it may be appropriate to provide technical assistance to reduce the extent of deficiency. The need for, and potential benefits of, the technical assistance must be weighed against the costs of providing such assistance, including the intangible cost of Federal intrusion and the possibility that the results of technical assistance may not be successful. Methods available include, but are not limited to, the following:

(1) Tell the grantee what the problem is and require the grantee to resolve it.

(2) Contract for specialized technical services to assist the grantee.

(3) Call on other available organizations to supply appropriate assistance--private foundations, State organizations, and associations of similar organizations.

(4) Provide the grantee with suggested remedies which have been successfully utilized by other grantees.

(5) Provide direct assistance through site visits or through grantee visits to headquarters or regional offices.

(6) If warranted, provide substantial technical assistance directly by Federal personnel.

(b) Multiple Program Responsibility. Where a grantee receives grants from several programs within a PHS agency, or from several PHS agencies, an attempt should be made to coordinate technical assistance by designating either a lead program, or a lead PHS agency/PHS regional office. In certain cases, PHS regional offices may find it beneficial to utilize the resources of the Regional Director's Office to provide technical assistance.

700.7 Advocacy Organizations

(a) Intent of This Section. This section is not intended to limit in any way the eligibility of advocacy organizations to receive grants nor to allow approval or disapproval of the goals of any advocacy organization to affect the PHS agency's decision whether or not to award a grant. The intent of this section is to reflect recognition of the risks associated with making grants to advocacy organizations.

(b) General Considerations

(1) Assistance awards to advocacy organizations raise special problems when the purposes of the organization diverge from or conflict with the purpose of the grant project. The organization's strong commitment to its own goals involves a higher-than-usual risk that grant funds will be misused. Even when the organization's honesty, competence, and management systems are impeccable, the divergence of purposes requires an unusual degree of good judgment in awarding the grant and monitoring the project. Special risks associated with such projects may include the following:

(i) An advocacy organization may be placed in a government sponsored position of great influence with persons of special vulnerability.

(ii) A cause which conflicts with the purpose of the grant may be facilitated and given special strength.

(iii) Personnel choices may be made for reasons foreign to the purpose of the grant.

(iv) There may be special motivations to misjudge defaults or deficiencies of participants or to provide special benefits to employees or beneficiaries.

(2) Special care must be taken in making awards to organizations espousing an advocacy position that is not germane to or conflicts with the purposes of the award. In making such awards, the awarding agency shall formally assess the sensitive areas, incorporate appropriate controls in the award document, and provide for close monitoring and appropriate reporting. (See section 700.8(b) for reporting requirements.)

(3) If an organization's commitment to its own goals involves the strong likelihood that grant funds may be misused, or if one of the factors in

(b)(1) above may result, the option of not awarding the grant should be carefully considered.

700.8 Responsibility and Reporting Requirements

(a) GMOs and cognizant program officials are responsible for reviewing all new discretionary grant applications, as well as ongoing funded grant projects, to determine if business management or programmatic practices are reasonable, or if applications contain sensitive matters supporting an advocacy position. Every effort should be made to identify these situations before an award is made since they can be more effectively dealt with at that time.

(b) Grants (new or competing extensions) to be awarded to an advocacy organization as described in sections 700.2(b) and 700.7 shall be reported as follows:

(1) At least 15 working days prior to the award of such grants, the PHS agency head or the Regional Health Administrator shall notify the Director, OM/PHS, that such a grant is to be awarded. Such written notification shall include:

(i) Name of the proposed grantee.

(ii) Purpose and description of the project.

(iii) Area(s) of sensitivity.

(iv) Amount and duration of expected support.

(v) Types of special controls, conditions, reports, and monitoring techniques to be used in assuring that the Government's interests are protected.

(2) At least 5 working days prior to the award of such grants, the Director, OM/PHS, will notify the Executive Secretary, HHS, that such a grant is to be awarded subject to this policy.

(c) Grants awarded to exceptional organizations shall be reported in accordance with section 700.5(c)(2).

700.9 Obtaining Additional Information

(a) When additional information is needed to determine whether the organization is exceptional, or to assess the nature and degree of risk, the GMO should determine whether the information is available from within the Department or from another Federal agency. If the information is available, it should be obtained from that source.

(b) If it cannot be obtained from within the Department or from another Federal agency, the organization may be requested to provide the information. In evaluating information in this manner, consideration should be given to whether it is properly attested to or validated.

(c) In most cases, prior to award and especially where no site visits have been conducted in the previous 6 months or previous site visits did not address the problem, the GMO and selected cognizant program officials should make a site visit to evaluate the organization's business management practices and programmatic capabilities.

(d) The GMO or the audit liaison representative must review pertinent information concerning such an organization and determine, if appropriate, the need for requesting an audit survey of the organization's business management practices.

(e) If matters other than business management competence (or related areas) are also to be covered in a survey, consideration should be given to assembling an ad hoc team from program, audit, and other professional staffs to perform the assessment.

PART 701 - THE HHS ALERT SYSTEM

Sec.

701.0 Background and Purpose
701.1 Applicability
701.2 Policy
701.3 Submission of Alert Information to HHS

Appendix 701-A - Alert Lists

701.0 Background and Purpose

(a) The Department of Health and Human Services (HHS) is concerned that mismanagement or other applicant/recipient deficiencies are not being shared with other awarding components in order that special precautions may be taken to protect the Federal interest in financially assisted activities. This sharing of such information will aid awarding components in making better management decisions on the award and continued funding of grant and cooperative agreement programs.

(b) The purpose of this part is to provide PHS internal operating procedures for the implementation of the Department's policy.

(c) This part also supplements other sources of information and should be read in conjunction with part 700, Exceptional Organizations, of the Grants Administration Manual (GAM); and the HHS assistance debarment and suspension regulations in 45 CFR Part 76.

701.1 Applicability

This part applies to all PHS grant and cooperative agreement programs. For alert procedures concerning PHS procurements, see HHS Procurement Circular 84.01 of the HHS Procurement Manual.

APPENDIX B

CO-SITING OF TITLE X CLINICS WITH ABORTION SERVICES

ESTIMATES OF CO-SITING OF TITLE X CLINICS WITH ABORTION SERVICES

GRANTEE/ DELEGATE	HOSPITAL	PLANNED PARENTHOOD	PUBLIC HEALTH	OTHER NON-PROFIT	TOTAL
REGIONS					
I	6	0	0	0	6
II	9	5	0	2	16
III	4	5	0	1	10
IV	2	3	0	0	5
V	4	2	0	0	6
VI	0	0	0	0	0
VII	1	3	0	0	4
VIII	1	1	0	1	3
IX	18	12	2	2	34
X	0	0	0	1	1
1986 TOTALS	45	31	2	7	85
[1982 TOTALS	46	21	3	4	74]

Title X Agencies with Abortion Services

Region I

CO-SITE NAME	CO-SITE-LOCATION
I. Hospitals:	
Hale Hospital	Haverhill, MA
Boston City Hospital	Boston, MA
Children's Hospital	Boston, MA
Hartford Hospital	Hartford, CT
New Britain General Hospital	New Britain, CT
Women and Infants Hospital	Providence, RI

Region II

CO-SITE NAME	CO-SITE-LOCATION

New Jersey

I. Hospitals:

Atlantic City
Hospital Center at Orange
Newark Beth Israel
University of Medicine and
Dentistry of New Jersey

II. Planned Parenthoods:

Planned Parenthood of Monmouth County

III. Other Nonprofits:

Hudson Health Service

New York

I. Hospitals:

Metropolitan	NYC
Harlem	NYC
Columbia Presbyterian	NYC
Buffalo General	
Deaconess	Buffalo

II. Planned Parenthood:

Upper Hudson
Schenectady and affiliated
counties
Tompkins
New York City

III. Other Nonprofits:

Green County Family Planning
Service

Region III

CO-SITE NAME	CO-SITE-LOCATION
I. Hospitals:	
Jefferson Family Planning Serv.	6050 New Hospital Building 111 South 11th Street Philadelphia, PA 19107
Temple University Hospital	OB/GYN Associates Family Planning Service 3401 N. Broad Street Philadelphia, PA 19107
Women and Children Health Serv., Inc.	Pennsylvania Hospital 700 Spruce Street - Suite 200 Philadelphia, PA 19107
Hahnemann Medical College & Hospital	Family Planning Service 230 N. Broad Street Philadelphia, PA 19102
II. Planned Parenthoods:	
Planned Parenthood Association	209 Ninth Street Pittsburgh, PA 15222
Planned Parenthood of Southeastern PA	1220 Sansom Street Philadelphia, PA 19102
Planned Parenthood Assoc. of Maryland	610 N. Harvard Street Baltimore, MD 21201
Planned Parenthood of Annapolis	1819 Bay Ridge Avenue Annapolis, MD 21403
Delaware League for Planned Parenthood	625 Shipley Street Wilmington, Delaware 19801
III. Other Nonprofits:	
The Women's Health Center	3418 Stanton Avenue, S.E. Charleston, W.VA 25304

Region IV

CO-SITE NAME	CO-SITE-LOCATION
I. Hospitals:	
Grady Hospital	Atlanta, Georgia
University Medical Center Hospital	Charleston, SC
II. Planned Parenthoods:	Louisville, Kentucky
	Memphis, Tennessee
	Nashville, Tennessee

Region V

CO-SITE NAME	CO-SITE-LOCATION
I. Hospitals:	
Illinois Masonic Hospital	Chicago, Illinois
Cleveland Metropolitan General Hospital	Cleveland, Ohio
Mt. Sinai Medical Center	Cleveland, Ohio
Akron City Hospital	Akron, Ohio
II. Planned Parenthoods:	
Planned Parenthood of Central Ohio	Columbus, Ohio
Planned Parenthood of Mid-Michigan	Ann Arbor, Michigan

Region VI

CO-SITE NAME	CO-SITE-LOCATION
None	

Region VII

CO-SITE NAME	CO-SITE-LOCATION
I. Hospital:	
Broadlawns Medical Center Family Planning	1800 Hickman Road Des Moines, Iowa 50314
II. Planned Parenthoods:	
Planned Parenthood of Central Missouri, Inc.	800 North Providence Road Columbia, Missouri 65201
Planned Parenthood of Western Missouri and Kansas	1001 East 47th Street Kansas City, Missouri 64110
Planned Parenthood of Mid-Iowa	851 19th Street Des Moines, Iowa 50306

Region VIII

CO-SITE NAME	CO-SITE-LOCATION
I. Hospitals:	
University of Colorado Health Sciences center	
II. Planned Parenthoods:	
Planned Parenthood of Billings	
III. Other non-profits:	
Boulder Valley Clinic	

Region IX

CO-SITE NAME	CO-SITE-LOCATION
I. Hospitals:	
Harbor/UCLA Medical Center	100 W. Carson St. Torrance, California 90509
Long Beach Memorial Hospital	2801 Atlantic Avenue Long Beach, CA 90801
Cedars-Sinai Medical Center	8700 Beverly Blvd. Los Angeles, CA 90048
Los Angeles County/USC Medical Center	Women's Hospital 1240 N. Mission Rd. Los Angeles, California 90033
Martin Luther King, Jr. General Hospital	12021 S. Wilmington Avenue Los Angeles, CA 90024
UCLA Medical Center	10833 Le Conte Avenue Los Angeles, CA 90024
UC/San Francisco General Hospital	1001 Potrero Avenue San Francisco, CA 94110
Riverside General Hospital	9851 Magnolia Avenue Riverside, CA 92503
Molokai General Hospital	Kaunakakai, Molokai 96748
Queen's Medical Center	1301 Punchbowl St. Honolulu, Hawaii 96813
Kapiolani Women's and Children's Medical Center	1319 Punahou St. Honolulu, Hawaii 96826
Department of Health Services LBJ Tropical Medical Center	Pago Pago, American Samoa 96799
Kosrae State Hospital	Lelu, Kosrae, Eastern Caroline IS. 96944
Pohnpei State Hospital	Kolonia, Ponape, Eastern Caroline IS. 96941

Page 2 Region IX

Truk State Hospital	Moen, Truk, Eastern Caroline IS. 96942
Yap Memorial Hospital	Kolonia, Yap, Western Caroline IS. 96943
MacDonald Memorial Hospital	Koror, Palau, Western Caroline IS. 96940
Armer Ishoda Memorial Hospital	Majuro, Marshall IS. 96960

II. Planned Parenthoods:

Alameda/San Francisco Planned Parenthood	1660 Bush St. San Francisco, CA 94109 and 482 W. McArthur Blvd. Oakland, CA 94609
Planned Parenthood of Marin	20 H St. San Rafael, CA 94901
Planned Parenthood of Monterey County	5 Via Joaquin Monterey, CA 93940
Planned Parenthood of Sacramento Vally	1507 21st St. Sacramento, CA 95814
Planned Parenthood of Santa Barbara County	518 Garden St. Santa Barbara, CA 93101
Planned Parenthood of Santa Cruz County	212 Laurel St. Santa Cruz, CA 95060
Planned Parenthood of Santa Clara County	1991 The Alameda San Jose, CA 95126 and 2660 Solace Pl. Mountain View, CA 94040

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Planned Parenthood World Population/Los Angeles	1920 Marengo St. Los Angeles, CA 90033 and 14120 Magnolia Blvd. Sherman Oaks, CA 91403
Six Rivers Planned Parenthood	2316 Harrison Avenue Eureka, CA 95501

III. Public Health Departments:

H. Claude Hudson Comprehensive Health Center	2829 S. Grand Avenue Los Angeles, CA 90007
El Monte Comprehensive Health Center	3350 N. Johnson Avenue El Monte, CA 91731

Other Non-profits

Feminist Women's Health Center	6221 Wilshire Blvd. Los Angeles, CA 90048
Westside Women's Health Care Project	1711 Ocean Park Blvd. Santa Monica, CA 90405

Region X

CO-SITE NAME	CO-SITE-LOCATION
I. Non-profits:	
Takilma Peoples Clinic	Takilma, Oregon

The CHAIRMAN. Mr. Glasow.

Mr. GLASOW. I am Richard Glasow, the education director of the National Right to Life Committee in Washington, DC, and I am very pleased to be here and very honored to be here.

We are grateful for the opportunity to present the views of the National Right to Life Committee on Senate bill 1366, authorizing and revising title X of the Public Health Service Act to the Committee on Labor and Human Resources of the U.S. Senate.

The National Right to Life Committee is this Nation's major pro-life organization, comprised of 50 State organizations and over 2,000 chapters. Our objective is to gain or assure legal protection for all innocent human beings. Thus, we are involved primarily in the issue of abortion which takes the lives of over 1.5 million unborn children each year.

Since our inception in 1973, we have also expressed concern for and worked for the protection of infants born with handicaps and the vulnerable elderly. More recently, we have recognized that the same forms of discrimination in medical care and legal protection that make the unborn, the handicapped newborn, and the elderly vulnerable also are a danger to all individuals with handicaps.

Summarily put, our issues are abortion, infanticide and euthanasia. We have never had, and still do not have a position on contraception. Our members have views which run the gamut on the issue of contraception.

We have many concerns with the title X Program as it has been implemented over the years. Most of these concerns will be addressed by other witnesses here today. Therefore, we will address a new concern raised by section 8 of Senate bill 1366.

This section would amend title X to authorize grants for "community-based informational educational programs, such as school-based health clinics." The connection of the proposed amendments to school-based clinics, which I will abbreviate as SBC's, was publicly acknowledged by a spokesman for the pro-abortion National Family Planning and Reproductive Health Association, the trade association lobbying arm of the family planning industry.

In a story in the Washington Post on Wednesday, July 29, 1987, Scott Swirling, executive director of the association, stated that the bill would indeed fund school-based clinics. His exact words were, "It is not the case that new research money will be going to abortion-causing drugs"—and this is the key part coming—"nor is the bill intended solely to fund school-based clinics."

SBC's have engendered great controversy across the nation, in part because of the inevitability that abortions and abortion counseling and referrals are, and will likely continue to be part of their activities.

This point need not even be debated in this context, since it is specifically required under the title X guidelines that abortion counseling and referral be included in the program.

The first of three primary reasons why pro-life advocates have sought to prevent the establishment of SBC's is their promotion of abortion. Speeches and publications from clinic advocates document four types of activities clearly linking the SBC's and abortion—both direct and indirect abortion referrals, pro-abortion sex education, underhanded tactics to discredit the pro-life opposition,

and promotion of the abortion pill RU 486. I will briefly touch on two of those.

School clinic proponents understand that even if the facility does not itself perform abortions, and none do at the moment, SBC's utilize the authority of the schools to funnel a captive clientele of students into pregnancy testing and abortions whether or not parents have signed a permission slip authorizing the SBC to treat their child for anything, much less abortion.

In other words, any SBC in a school may, and probably will, serve as a conduit for girls to abortion facilities. This situation would dramatically worsen if $10 million in title X funds started to flow into the school clinics because under the current guidelines the staff could use the federal law to thwart any restrictions on performing abortion referrals without parental knowledge or consent.

It is true that only a small number of school-based facilities currently receive title X funds, but they exert an influence all out of proportion to their number because SBC proponents argue that their policies are the standard that all other clinics should adopt.

Another abortion-related issue that has not played a role in past debates over title X could be very important in the future because of the proposed $10 million increase in funding in Senate bill 1366 for "applied contraceptive research and evaluation, and specifically to promote the development, marketing and evaluation of new and improved contraceptive devices, drugs and methods," including "grants to public and non-profit entities and contracts with public and private entities and individuals."

This proposal is very disturbing to us because of the strong likelihood, if not certainty, that the funds will support research, development and even marketing of the abortion pill RU 486, which has been consistently mislabeled as a contraceptive by its promoters, but it was actually an abortifacient.

Supporters of the bill in the United States such as the Population Council project that it could be marketed within the next 5 years, but they are having trouble convincing a domestic manufacturer to assume the cost.

Clearly, the provisions of Senate bill 1366 will fit their needs exactly by providing funding even so far as to use government money to support developing and marketing by profitmaking companies. The potential for distributing the abortion pill to teenagers through school clinics was not lost on proponents.

I will abbreviate my next two points and summarize, Mr. Chairman, by saying that in view of the foregoing, the National Right to Life Committee will oppose any effort to involve the Federal Government in school-based health clinics unless the problems are resolved in the authorizing legislation.

Senate bill 1366 would authorize the use of title X funds in school-based clinics. Under the title X guidelines, these clinics would be required to provide confidential abortion counseling and referral.

The National Right to Life Committee opposes the introduction of abortion services in this Nation's high schools.

Thank you, sir.

[The prepared statement of Mr. Glasow follows:]

Testimony of

Richard D. Glasow, Ph.D.

Director of Education

National Right to Life Committee

on S. 1366

To revise and extend Title X of the Public Health Service Act

Submitted to

the Committee on Labor and Human Resources

U.S. Senate

July 30, 1987

National Right to Life Committee

419-7th Street, Northwest

Suite 402

Washington, D.C. 20004

(202) 626-8820

INTRODUCTION

We are grateful for the opportunity to present the views of the National Right to Life Committee, Inc. on Senate Bill 1366, reauthorizing and revising Title X of the Public Health Service Act, to the Committee on Labor and Human Resources of the U.S. Senate.

The National Right to Life Committee is this nation's major pro-life organization comprised of 50 state organizations and over 2,000 chapters. Our objective is to gain or assure legal protection for all innocent human beings. Thus we are involved primarily in the issue of abortion, which takes the lives of over 1.5 million innocent unborn children each year. Since our inception in 1973, we have also expressed concern for and worked for the protection of infants born with handicaps and the vulnerable elderly. More recently we have recognized that the same forms of discrimination in medical care and legal protection that makes the unborn, the handicapped newborn, and the elderly vulnerable, also are a danger to all individuals with handicaps. Summarily put, our issues are abortion, infanticide, and euthanasia.

We have never had--and still do not have--a position on contraception. Our members have views which run the gamut on the issue of contraception.

We have many concerns with the Title X program as it has been implemented over the years. Most of those concerns will be addressed by other witnesses here today; therefore, we will address a new concern raised by Section 8 of S. Bill 1366. This section would amend Title X to authorize grants for "community-based informational and educational programs," such as school-based health clinics (SBC).

The connection of the proposed amendments to SBCs was publicly acknowledged by a spokesman for the pro-abortion National Family Planning and Reproductive Health Association (the trade association and lobbying arm of family planning industry). In a story in the **Washington Post** on Wednesday, July 29, 1987, Scott Swirling, executive director of the association, stated that the bill would indeed fund school-based clinics. His exact words were: "It is not the case that new research money will be going to [abortion-

causing drugs] nor is the bill intended solely to fund school-based clinics" (emphasis added) (Rich 1987, A21).

SBCs have engendered great controversy across the nation, in part because of the inevitability that abortions and abortion counseling and referrals are--and will likely continue to be--part of their activities. This point need not even be debated since it is specifically required under the Title X guidelines that abortion counselling and referral be included in the program.

SCHOOL-BASED CLINICS PROMOTE ABORTION, BYPASS PARENTS

So intense is public concern over teen pregnancy that otherwise cautious people will ignore the tough political, social, and moral questions that must be discussed before establishing SBCs. We will first examine the three primary reasons why pro-life advocates have fought to prevent the establishment of SBCs: (1) their promotion of abortion referrals, (2) how they undermine parental rights, and (3) the absence of proven effectiveness in preventing teen pregnancies.

We will also mention five other important objections to clinics which do not touch as directly on the abortion issue but have been significant in public policy debates.

Section One
Promoting Abortion Referrals, Pro-Abortion Education, And Abortion Pills

Unfortunately, many policymakers and members of the public have unthinkingly accepted claims that SBCs do not promote abortion. Fairly typical of the assurances routinely given the public was the statement in the Los Angeles **Daily News** attributed to Jackie Goldberg, the Los Angeles school board member who co-authored the proposal which established two clinics. "We don't intend to have an abortion referral service in the clinic," she said. "It's really sad how a good idea can be ruined by going

around and yelling abortion," she lamented. (Rifkin 1986, 1)

These claims are at best half truths. Clinic supporters recognized several years ago that their pro-abortion policies and activities posed a potentially significant problem. In an important article published in March 1985 summarizing SBC activities, Joy Dryfoos observed that "the issue of abortion is frequently finessed in these clinics (Dryfoos 1985, 75)." Her choice of words and the description of policies earlier in the article would alert the reader that the SBC staff members were indeed employing a "subtle and tactful strategy" (to quote the dictionary definition of "finesse"). By being less than candid, SBC proponents were able to achieve their objective of arranging for abortions without arousing either the parents' or community's indignation.

Speeches and publications from clinic advocates document four types of activities clearly linking the SBCs and abortion: both direct and indirect abortion referrals, pro-abortion "sex education," underhanded tactics to discredit pro-life opposition, and promotion of the abortion pill, RU 486. Policymakers unfortunately often focus so much attention on the controversy over the distribution of contraceptives within the clinic that they overlook the importance of the abortion connection.

Practical considerations--the need to keep controversy to a minimum until the clinic is established--force SBC proponents to use "comprehensive services" as the cover story for their real agenda.

Direct and Indirect Abortion Referrals

School-clinic proponents understand that even if the facility does not itself perform abortions--and none do at the moment--SBCs utilize the authority of the schools to funnel a captive clientele of students into pregnancy testing and abortions whether or not parents have signed a permission slip authorizing the SBC to treat their child for anything, much less abortion. In other words, any SBC in a school may--and probably will--serve as a conduit for girls to abortion facilities. Much of what follows describes how school-based clinics are now operating--mostly without Title X funds. However, an infusion of Title X funds under current policy guidelines might accomplish one thing--doing away with the current

subterfuge which masks abortion services.

Three Key Definitions

"Abortion Counseling"

Three definitions used to describe the range of abortion-related activities performed by SBCs are often deliberately used interchangeably by clinic proponents and staff members to confuse and mislead policymakers and the public. Although the terminology in a given clinic may be slightly different than the one explained here, the three general categories of activities will be the same.

First, when a SBC is involved with "abortion counseling," it means the clinic informs a pregnant girl about all of her "legal options," including her right to obtain an abortion without parental knowledge or consent. Organizations that do abortion counseling, such as Planned Parenthood's affiliates and other federally funded agencies, claim that they employ "non-directive" methods which describe all of the alternative courses of action, without promoting any one. (Wattleton 1981, 23)

In view of this, the staff may even claim that they do not perform "abortion" counseling per se since they present abortion as one option among many. For example, the Center for Population Option's **Guide to Implementing Programs** uses the term "pregnancy counseling," but this is semantic gymnastics (Hadley 1986, 89). The real agenda would be apparent if the clinic released statistics revealing how many girls who had pregnancy tests had abortions and how many carried their babies to term. However, in most cases clinics do not keep accurate records on abortions, only on girls who have their babies (Kenney 1986a, 45; Dryfoos 1986b, 6-7). All of these services, including the result of the pregnancy test, are completely confidential.

"Abortion Referral"

Second, "abortion referral" describes more specific assistance in arranging an abortion, such as giving the pregnant girl the name and location of the nearest abortionist or abortion facility and informing her about possible sources of funding for the abortion.

A story appearing in the **New York Times** on October 15, 1986 about the Martin Luther King Jr. High School clinic in Manhattan provided an excellent example of how the SBC performs abortion referrals (Perlez 1986c). The article described referrals made by Fran Combe, the resident nurse practitioner at the Manhattan SBC. During the previous year, according to the **Times**, five of the ten girls who were found to be pregnant at Combs' clinic had abortions at the Eastern Women's Center, "the abortion clinic at 14 East 60th Street that she [Ms. Combe] most frequently recommends." Combe also directed two other pregnant girls to another abortion facility. (The remaining three young women had their babies.)

"Providing" or "Performing Abortions"

Third, "providing" or "performing" abortion describes cutting up the baby and placenta and removing the pieces from the girl's uterus using a suction curette or looped-shaped steel knife. The surgery is carried out in a facility separate from the school clinic. Free-standing facilities, such as the Eastern Women's Center in New York City, perform approximately 83% of the 1.6 million abortions done each year, but individual physicians and hospitals also perform a substantial number (Henshaw 1987, 67).

At this writing, no school-based clinic performs abortions (Hadley 1986, 34); however, some organizations which sponsor or are linked to school-based clinics do. For example, the St. Paul-Ramsey Hospital Center, which operated the widely copied SBCs in Minnesota, performs both first- and second-trimester abortions.

Three Categories of Abortion Referrals

Since no SBCs function as abortion clinics yet, the public controversy focuses on how they assist girls to obtain abortions through counseling and referrals. The latter issue has received the more attention for two reasons. First, evidence of referrals would establish the clearer cause-and-effect relationship between SBCs and abortions. And two, in many instances SBC proponents have hotly denied "promoting" abortion through referrals, but have been less reticent to admit performing what we have just described as

"abortion counseling."

This admission alone should be a sufficient evidence of the SBC-abortion link, and the following review of the three types of arrangements in school clinics for abortion referrals should make the case against them even stronger.

SBCs are determined by hook or by crook to channel teens into abortion clinics. How they accomplish this depends on the laws and regulations governing the clinic. Two types of clinics send the pregnant girl directly to the abortionist, while the other type arranges for the surgery indirectly through a third party.

Direct Abortion Referrals Under Federal and State Law

The first category are clinics directly referring for abortion that do so on the grounds that they are required to do so by either federal or state law.

Federal Rules--Title X

Only a small number of school-based facilities receive federal funds through Title X (title ten) of the Public Health Services Act. But they exert an influence all out of proportion to their number because SBC proponents argue that their policies are the standard that all clinics should adopt.[1] At a workshop at the annual national SBC conference in October 1986, Asta Kenney, research associate at the strongly pro-clinic and pro-abortion Alan Guttmacher Institute, asserted that both the legal requirements of the federal guidelines and the "standards of medical ethics" require that SBCs receiving Title X funds provide confidential pregnancy testing and abortion counseling and referral (Kenney 1986b). In other words, under the policies that Kenney described, the SBCs receiving Title X funds must refer pregnant teens directly to abortion mills even if their parents have not given their permission.

Kenney's statement regarding Title X requirements unfortunately is consistent with the interpretation that Dr. Otis Bowen, secretary of the Department of Health and Human Services, articulated during testimony before Congress in February 1987 (Archibald 1987). However, right-to-life supporters have maintained that the actual wording of the Title X

legislation passed in 1970 did not require Title X grantees to provide abortion counseling and referrals, and in fact requires a complete separation of the Title X services from any abortion-related activities, such as operating an abortion mill. In any case, Planned Parenthood and other leading Title X grantees have stated publicly on several occasions that they will continue performing abortion counseling and referrals until the federal Department of Health and Human Services changes its policies and compels them to stop.

It is also important to note that two other federal programs which currently provide a small amount (about 2%) of the funding for SBCs nationwide have been interpreted to make the same type of requirements for confidential abortion counseling and referrals (Lovick 1986, 13). According to an authoritative book published in 1986 by two attorneys and a pediatrician, Titles XIX (title nineteen, Medical Assistance) and XX (title twenty, Aid to Families With Dependent Children) of the Social Security Act require participating agencies to give minors services without parental knowledge and consent (Morrissey 1986, 63).

Proposed federal legislation such as S. 1366 would authorize spending millions of dollars on SBCs and would require the clinics to offer confidential abortion counseling and referrals (U.S. Cong., House, 1987).

State Requirements

SBC proponents also contend that in many places state law requires them to provide confidential abortion counseling and referrals without parental knowledge or consent. The October 1986 issue of **Clinic News**, published by Center for Population Option's clinic Support Center, listed thirty-three states and the District of Columbia where minors are empowered to give their own consent to obtain pregnancy tests and counseling.[2] In twelve of those states the teens can consent for all of their own medical care, including pregnancy testing and abortion. One wonders how many parents are informed about this interpretation of the state law when their school board or city council is considering opening school clinics.

Direct Abortion Referrals
At Non-Title-X SBCs

A second category of clinics which refer directly, Kenney argued, are

those which--in the absence of local or state laws or school regulations to the contrary--ought to assume that the same rules of confidentiality that govern family planning clinics operated outside the school, also apply to SBCs within the schools.

Since much of the impetus for starting SBCs came from Planned Parenthood and other Title X grantees, it is not surprising that they are trying to use the same policies in the schools that they have employed for the last decade and a half in their free-standing clinics.

According to Kenney, federal programs which provide most of the SBC funding, such as the federal Maternal and Child Health (MCH) block grant (Title V) of the Public Health Services Act, do not have specific stipulations either requiring parental involvement or allowing for confidentiality (Kenney 1986b). According to a report compiled by the Center for Population Options during 1986, the MCH block grant provided twenty-seven percent of the funding for SBCs (Lovick 1986, 13).

"Demands" of
Medical Ethics

In addition to fulfilling legal requirements, "SBC practitioners," according to the SBC operating manual published in October 1986 by Center for Population Options, also "adhere to standards of medical ethics which state that pregnant patients are entitled to know all of their legal options [including of course, abortion]" (Hadley 1986, 34). In other words, clinic personnel believe that both legal and ethical considerations compel the clinic staff to give pregnant girls information about abortion. If she decides on having an abortion, they will refer her to an abortion facility.

Indirect Abortion Referrals
at Non-Title X Clinics

In addition to the two methods for sending the pregnant teen directly to the abortionist, SBCs also arrange for indirect abortion referrals. This situation arises when either the school's regulations or the parents' consent form specifically prohibit the SBC from performing abortion counseling or referring directly for abortion. The clinic staff have two stratagems to circumvent these rules.

Third-Party
Abortion Referrals

In the first instance, the clinic staff simply sends the pregnant girl to an agency outside of the school, such as the local family planning or public health agency, which itself does not perform abortions, but which in turn arranges for her abortion with another agency or facility, which does perform abortions.

The director of public policy for Center for Population Options, Jodie Levin-Epstein, explained how this policy operates during her speech at the workshop at the Denver SBC meeting titled **Parents: Consent and Confidentiality** (Levin-Epstein 1986). "In practice, it is our understanding," she said, "that where a parent has not given consent for participation in a program, or in those instances [where] there is a checkoff for a particular program and the student for whatever reason isn't supposed to be served by that [SBC] program according to the parental consent, **the program refers for [that] service, or handles it in whatever way has been articulated by the advisory board.**" (Emphasis added)

Commenting on that policy at the same workshop, a nurse practitioner with the Orr High School Clinic in Chicago said "We do not even mention abortion in the school-based clinic. If it does come up, we refer them out. We don't talk about it" (Holt 1986).

Steve Purser, health planning coordinator in charge of the Balboa High School clinic in San Francisco, gave a more thorough example of how this policy operates during a workshop on March 6, 1986 at the annual meeting of the National Family Planning and Reproductive Health Association (Purser 1986). His remarks are worth quoting at length. Although his clinic is heavily supported by federal Title X money, which would normally would require abortion referrals without parental consent, he will not do that because "we don't want to usurp the parents' role." "The last thing you want to do, " emphasized Purser, "is to have a parent sign a consent form saying I want to exclude 'x' service, then provide that service to the child." Then he went on to reveal that the actual reason for obstensibly being so respectful of the parent's wishes was pure politics. If the clinic gave unauthorized services, "[t]he school board would shut us down--literally," he stated emphatically.

Turning next to the issue of referrals, Purser asked himself the question of "What do we do if they [students] come to us and the parent says 'I don't want my child to receive family planning'?" If that situation arises (or if there is no consent form at all), he explained "[t]hey are referred to a clinic that's about a mile-and-a-half from us, which is another health department clinic that provides family planning services." When the teenager is referred to the outside clinic, Purser stated, they "are no longer a student receiving health care at the high school, [but] they become part of the [general] health systems population." Since the outside city health facility is funded by Title X, it is not under the same restrictions as the school clinic.

This point about the third pattern of indirect abortion referral should be emphasized because it is so important. If the SBC is prohibited from, say, referring the girl for an abortion, then clinic personnel can circumvent the parents' wishes simply by sending the pregnant girl to an agency or organization outside the school which itself does not perform abortions but which will refer the girl to someone who does perform abortions. Technically, of course, the SBC has not referred the girl directly for abortion.

Once a clinic opens in a school, indirect abortion referrals would be very difficult to stop or regulate, particularly since the clinic staff would probably claim that their medical ethics require them to perform at least indirect referrals for any medical services.

Third-Party
Pregnancy Test Referrals

Another even more intellectually disreputable method of avoiding any appearance of providing direct abortion referrals while indirectly accomplishing the same purpose is to refer any girl suspected of being pregnant to an agency outside of the school where she can get the pregnancy test done. This technique was described at a conference in San Diego in November 1986 by Kathleen Arnold-Sheeran, a long-time nursing and administrative staff member of the St. Paul clinics and currently director of the National Association of School-Based Clinics (Arnold-Sheeran 1986).

She explained that the clinic staff in the St. Paul program was careful to inform the student body about the Minnesota state law prohibiting the

clinic from making abortion referrals without parental notification. However, at the same time, the staff ensured that the students knew the location of another nearby facility where they could obtain a free confidential pregnancy test and abortion referrals. "We certainly talk to kids and let them know there are options available," she stated, but "we just can't go into any details talking about abortions."

The result, of course, is that the pregnant girls who are considering abortion "don't come to us for their pregnancy tests," Arnold-Sheeran pointed out. She implied that they obtained their pregnancy tests at the outside agency that the clinic recommended, which performed the abortion or gave them a referral.

In addition to giving the appearance that the SBC was not in the abortion business, the arrangement has an additional benefit. Since the pregnant girls avoided having pregnancy tests at the SBC and only girls who want to have their babies obtained their pregnancy tests there, the statistics were heavily skewed in one direction, which gave the erroneous impression that the clinic strongly promoted giving birth and not abortion. "Ninety-eight percent that [sic] come in for pregnancy tests continue their pregnancy," she stated.

Tactics to Thwart Opposition

SBC proponents realize that linking abortion to a clinic can amount to a "kiss of death" because the issue is so controversial that politicians do not want to have anything to do with it. No matter what position they take, politicians feel that they will end up alienating some group in the community (Katz 1986, 2).

Therefore, in order to neutralize pro-life opposition, the clinic advocates have generally utilized three tactics, which are sometimes employed alone, but, more frequently, together. (A fourth tactic widely used by SBC advocates to dodge embarrassing questions about the lack of evidence that clinics prevent pregnancies will be described briefly later. There we will examine how clinic proponents have successfully convinced policymakers to accept inadequate statistical data and meaningless measures of effectiveness.)

Meaningless Restrictions on Abortion Referrals

First, the SBC staff and supporters attempt to placate worried legislators by strongly asserting that the clinic will not perform abortion counseling and referrals. They are even willing to accept restrictions governing the operation of the clinic. If the issue of referrals comes up after the clinic has already opened, the staff will claim that the clinic does not offer that service. Often this half-truth appeases the politicians.

Judith Steinhagen, principal of the DuSable High School clinic in south Chicago, illustrated how this tactic is used during an interview on the "MacNeil/Lehrer Newshour" on November 24, 1986 (Mcneil/Lehrer 1986). In response to the observation by the TV correspondent that the leader of the clinic's opposition, the Reverend Hiram Crawford, was claimed to have said that pregnant girls are referred to local hospitals for abortions, Steinhagen responded strongly "That's a lie. That's a lie." Then, when the reporter probed more deeply about the actual arrangements for pregnant girls, Steinhagen acknowledged that some girls from her school had obtained abortions, but she asserted that "those referrals are not made by the school nor the clinic." Unfortunately, the reporter let her off of the hook by failing to ask about indirect abortion referrals.

As we have seen above, Steinhagen's statement only told half of the story. DuSable's clinic may not perform direct abortion referrals, but the staff will arrange for an indirect referral by sending the pregnant girl to an agency outside of the school, which in turn directs her to an abortionist.

Defaming Critics and Discrediting Their Questions

SBC advocates have adopted two other tactics that pro-abortion supporters have used consistently to deflect pro-life inquiries: attack the motives of the questionners and characterize their questions as either trivial or unworthy of consideration.

At the annual national SBC conference in October 1986, a speech by Joy Dryfoos, chairman of the board of the Center for Population Options, utilized both tactics to discredit critics (Dryfoos 1986c). First, she belittled the "detractors" of the clinics by characterizing them as "moralizers" who "have a field day of sermonizing, handwringing, trying to keep us off of their moral turf."

Then Dryfoos described her resentment that proponents of SBCs "are being hard pressed on every side to generate data to prove scientifically that clinics work--that they prevent pregnancy. . ." and so forth (Dryfoos 1986c). These requirements seemed unreasonable, in her opinion, since "the school-based clinic movement is being asked to justify itself in a much greater degree than most programs that I know about."

As an example, she cited the current substance-abuse prevention programs where millions of dollars are being spent without sufficient proof, in her opinion, that the efforts will achieve the desired results (Dryfoos 1986c).

Her objection ignores, of course, three fundamental differences between the SBCs and the initiatives among teens against drunk driving and substance abuse. The latter programs are almost entirely educational, promote abstinence and rehabilitation to get to the root cause of the problem, and are not nearly as invasive of the school environment as comprehensive health clinics.

SBC proponents often imply, when they do not pointedly declare outright, that SBC critics are insensitive to the health problems of inner-city minority teens because they oppose the clinics. The clear implication, of course, is that critics are callous, if not racist individuals, whose misgivings do not have to be taken seriously.

An article in the February 16, 1987 issue of **Newsweek** magazine provides an example (Kantrowitz 1986, 58). After describing the political opposition to clinics in Boston growing out of moral considerations, the story pointed out that "often, the clinics provide the only medical care the kids get." Moreover, the current director of the DuSable clinic told the magazine that "family planning is only one of 10 health programs--including regular examinations and prenatal care."

The reader is subtly led from one thought into another. Resistance to the clinic emanating from a narrow range of concerns over issues such as

abortion is somehow transformed into an attack on the whole program. Then, with a leap of logic, that narrow objection translates into callousness toward minority students who would use the clinic. Only narrow-minded bigots, imply the SBC proponents, would jeopardize a vitally needed health program because of one distasteful aspect.

This ploy enables SBC advocates to assume the moral high ground in the debate and puts critics of the clinics on the defensive. Not only do they have to fight to be heard on the substantive issues that they wanted to raise in the first place, but their whole effort is also tainted with an unearned bad image.

Critics have been so discredited in the eyes of the media that they are seldom, if ever, given a fair opportunity to present their alternative solutions to the inner-city teens health problems. Moreover, policymakers sometimes take the approach that the SBC is an "all-or-nothing" proposal. They will not agree that some controversial parts of the clinic's program could be dropped, or at least provided in a different location.

While most SBC proponents have opted for the "all-or-nothing" approach, others such as Paul Shaheen, executive director of the Michigan Council on Maternal and Child Health, a lobbying organization promoting SBCs, disagree (Shaheen 1987). Such unwillingness, he argues, can be counterproductive. Speaking in March 1987 at a workshop at the Children's Defense Fund's national conference on adolescent pregnancy prevention, he said "We do not have to fight the sexuality issue in the teen-clinic movement." "It ought to be managed," Shaheen continued, "so that it doesn't impede improving access to kids' health services, which is our number-one objective." Although his state-wide taskforce favored having every clinic offer the full-range of services, including abortion counseling and referrals, he recommended that each community decide independently what services would be appropriate. Despite suggestions from a few SBC proponents such as Shaheen that the issue be decided on its merits, not abusive rhetoric, critics of clinics continued to be assailed and their motives questioned. Nevertheless, the evidence is growing that policymakers are beginning to take parental and community concerns more seriously for a change and hopefully they will begin to be evaluated objectively.

Pro-Abortion "Sex Education"

In addition to referring pregnant girls for abortions, SBCs also promote abortion through their in-school education programs. The pilot programs in St. Paul and Baltimore, which have been widely emulated throughout the country, strongly emphasized the value of clinic personnel working closely with the school's health educators to develop the "reproductive health curriculum," and even to teach classes in order to establish rapport with the students (Dryfoos 1985, 73; Kapp 1986, 83).

This arrangement presents an extraordinary opportunity for the clinic staff to imbue the teens with pro-abortion concepts (usually described as presenting "all of the options") and to explain about the availability of pregnancy tests, of nearby abortion facilities, and of government funds to pay for abortions.

Douglas Kirby, the Center for Population Options' director of research, observed that the classroom presentations "not only serve an educational function, but a recruiting function as well" (Kirby 1985, 13). SBC expert Joy Dryfoos explained that the "clinic staff often conduct sex education and family life education classes in the school, so they have ample opportunity to encourage the student in the classroom to attend the clinic" (Dryfoos 1985, 73)

Finally, Kathleen Arnold-Sheeran, with thirteen years of experience in the St. Paul clinic stressed the importance of giving "lectures in the classes" at a workshop in San Diego in November 1986. "If you have a SBC without health education services, forget it," she emphasized, "it's no good" (Arnold-Sheeran 1986).

SBCs Pushing Abortion Pills?

Another abortion-related issue that has not played a role in past debates over Title X SBCs could be very important in the future because of the proposed $10 million increase in funding in S. Bill 1366 for "applied contraceptive research and evaluation, and specfically to promote the development, marketing, and evaluation of new and improved contraceptive devices, drugs, and methods," including "grants to public and nonprofit

private entities" and "contracts with public and private entities and individuals." This proposal is very disturbing because of the strong likelihood (if not certainty) that the funds will support research, development, and even marketing of the abortion pill, RU 486, which has been consistently mislabeled as an "contraceptive" by its promoters, but which is actually an abortifacient.

During 1986, the American public received its first thorough introduction to a new abortion pill, RU 486, that is being developed by a French company and tested throughout the world, including the United States. In the opinion of pill's developers, the drug has the potential to revolutionize the abortion debate by making early abortion an entirely private matter. The promoters initially publicized how the pill worked before the woman even recognized she was pregnant, but all of the research reports since mid-1986 have emphasized using it after the woman misses her menstrual period. In other words, the RU 486 advocates have attempted to give the false impression that the pill is a contraceptive, but it is clearly an abortifacient (Kaye 1986, 14; Baulieu 1985, 1-25; Franklin 1986, 24).

The manufacturer expects to market RU 486 in France during 1987 as a method to induce abortion within two weeks after the woman has missed her first menstrual period--in other words, when she is about four-to-six-weeks pregnant. Supporters of the pill in the U.S., such as the Population Council, project that it could be marketed here within five years, but they re having trouble convincing a domestic manufacturer to assume the costs. (Knox 1986, 10; Brody 1986, A27) Clearly, the provisions of S. Bill 1366 will fit their needs exactly by providing that funding, even so far as to use government money to support development and marketing by profit-making companies.

The potential for distributing the abortion pill to teenagers through school clinics was not lost on SBC proponents. In a story appearing in the **Boston Globe** on December 22, 1986, the chairman of the board of directors of the Planned Parenthood Federation of America, Dr. Allan Rosenfield, endorsed approval of RU 486 as a "major step forward for teenagers" (Franklin 1986, 1 and 24). He believed, reported the **Globe**, that if teenaged girls who suspected they were pregnant "knew they could come to a clinic for a pill when their period is late, they would probably show up a

lot earlier than they do now." Jonathan Brant, a Boston attorney specializing in health care issues, explained to the **Globe** that "[m]ost current restrictions, such as parental notification laws, would be unenforceable."

The French abortion pill, RU 486, is not presently ready for introduction in the U.S., but it represents only the tip of the iceberg. Research is underway on many other chemical abortion methods. In almost every case, there is very limited information about the short-term side effects, and absolutely no data on the long-term ramifications of any of these new drugs (Spitz and Bardin 1985, 260-262; Baulieu 1985, 1, 19)

Clearly clinics located inside of schools would be in an especially advantageous position to distribute abortion pills; therefore, one wonders whether clinics, in whatever current benign form that they make take at the moment, should be allowed to become entrenched so close to teenagers.

Abortion Connection Overlooked

Pro-life advocates should realize that debates over whether to distribute contraceptives in school clinics have in large measure overshadowed concerns over the much less public activity of abortion counseling and referrals and pro-abortion classroom instruction which routinely go on in SBCs.

A scandal in the New York City schools is a case in point. On October 5, 1986, members of the Board of Education were embarrassed to learn through front-page newspaper stories that nine school clinics had been operating for up to two years without their knowledge and approval (Perlez 1986a-g). In response to the public outcry, which focused primarily on the distribution of contraceptives without parental knowledge, the Board worked out a "compromise" modification of the policies in order to placate outraged parents. However, no one raised a question about the clinics remaining open within the schools to continue operating as abortion-referral agencies.

After a series of confrontations in cities around the country where the contraceptive debate became a lightning rod for community and parental opposition, clinic advocates have looked for ways to head off the conflict but still stay in the schools where they can counsel and refer for

abortions. "Be willing to make compromises," stressed Arnold-Sheeran, but "do not compromise on being in the school." Once the clinic opens, she explained, other services can be added afterward as they were in Kansas City clinic (Arnold-Sheeran 1986).

Section Two
Undercutting Parental Authority

Pro-life supporters are particularly sensitive to the issues of parental rights since abortionists routinely perform abortions on minor girls without parental knowledge or consent. SBCs undermine the parents' authority and responsibility by administering pregnancy tests, performing counselling, and referring their minor daughters for abortions without parental knowledge or consent.

School-based-clinic proponents maintain the appearance of involving parents and obtaining their consent to treat their children, but that is a facade for their real program. A closer study of the actual policies reveals that they believe that parents must be cut out in order to operate the clinics effectively.

SBCs often distribute parental consent forms that are vague enough to provide the clinics with a virtual carte blanche. Moreover, as we pointed out above, even in cases where either the parental form or school policy prevents a certain kind of "treatment," such as abortion, the staff will nevertheless send the teenager to an agency outside of the school which will provide the service.

While most clinics require nominal parental consent, they have employed some questionable methods to make that process essentially meaningless. Joy Dryfoos, one of the leading national proponents of school clinics, listed several examples, including having parents "sign a blanket consent form unrelated to any specific clinic visit," or having the consent form "apply for the entire period of the student's enrollment" (Dryfoos 1985, 73).

Even more disingenuous is the approach of Planned Parenthood of Muskegon, Michigan which utilizes a "negative" checkoff system. The clinic staff mails home a form and assumes that the parent has authorized treatment unless the parent signs and returns the form to prevent it. Not surprisingly, only one percent of the forms have ever made it back to the school (Muskegon Area Planned Parenthood 1985, 1).

Perhaps the most important new insight that came out of the two-day conference in Denver is the SBC proponents' almost missionary zeal to act as stand-in parents. Part of that task requires literally keeping two sets of

books.

At the **Parents: Consent and Confidentiality** session, Asta Kenney, an associate with Planned Parenthood's research arm--the Alan Guttmacher Institute--approvingly explained how clinic personnel take on themselves the right to decide what is most appropriate for a child (Kenney 1986b). In the case of family planning services, the staff keeps parents in the dark because, Kenney said, "[i]t is clearly in the child's best interests to be able to get those services. . . ."

Many parents would be surprised to be told that health professionals in their local schools have decided that they are not doing a proper job of parenting. Such ideas would seldom, if ever, be discussed publicly as a rationale for opening clinics because it would infuriate parents and many other members of the community.

Clinic staff members in the audience at the same workshop described several ways to maintain confidentiality, in the face of school requirements to open the records to parents (CPO Conference 1986). One apparently common tactic is to maintain two sets of health records for each student. One has general health information to show to the parents and another set has the confidential data which would not be shown to them. Another ploy is for the nurse to keep records about confidential services in her desk as part of "her own papers," which are her personal property.

Section Three
Misleading Claims of Effectiveness

SBC proponents consistently allege that the school clinics reduce teen abortions by reducing pregnancies. Actually the evidence shows that the supporters greatly misrepresent their "successes." Data about pregnancy rates in the pilot programs in inner-city schools in several cities, such as St.Paul, Baltimore, and Chicago is inadequate to support the SBC proponents' public assertions.

The elitist and arrogant ideology of the proponents of the clinics is apparent in their reluctance, if not downright refusal, to answer the tough questions about the effectiveness of SBCs in changing the behavior of teens, and especially in reducing pregnancy.

Clinic proponents have, for example, been highly successful in justifying establishment of new facilities aimed, we are told, at reducing teen pregnancy by demonstrating that the pilot clinics have reduced birth (or fertility) rates (Wallis 1985, 89; Pierce 1986; Mathews 1985, A3; Lardner 1986).

They are not the same thing. One can reduce the birth rate simply by increasing the number of abortions without affecting the total number of pregnancies at all! But it is a clever smoke-screen. Many reporters and policy makers have not grasped the difference, and this leads them into accepting the establishment of SBCs uncritically.

However, in late 1985 and into 1986, critics of clinics began to point out the glaring deficiencies in the "proof" that the St. Paul clinic decreased pregnancies. In response to this pressure, clinic supporters turned to another prototype program in Baltimore, which will probably replace St. Paul as the example of what a school clinic can supposedly accomplish. The researchers from Johns Hopkins University in Baltimore claimed that their two SBCs reduced the pregnancy rates among inner-city girls during the twenty-eight month study (Zabin 1986; Alan Guttmacher Institute 1986; Brozan 1986, C3).

Critics have pointed out two types of deficiencies in the Baltimore study: the failure of the researchers to take into account external factors that could have dramatically influenced the outcome of the study, and shortcomings in the methodology used in the study itself (Gasper 1986; Kasun 1986; Demsko 1987).

After analyzing the statistical data, the best we can say is that the claims of effectiveness for the St. Paul and Baltimore clinics in reducing teen pregnancy rates remain unproven. At worst, evidence from the clinics in Michigan and Missouri points to the inevitable conclusion that the teen birthrate dropped because the girls procured more abortions, not because the pregnancy rates went down (Muskegon Area Planned Parenthood 1985, 1; Kenney 1986, 45).

Indeed, even supporters recognize the inadequacy of their statistics and have attempted to shift attention to a different index of "success." For example, Douglas Kirby, Director of Research at the Center for Population Options, suggested measuring effectiveness using attendance rates at the clinic or the success in preventing school dropouts among pregnant

girls (Kirby 1985, 13-14). However, decisionmakers should not accept these substitutes. If clinics are not effective in achieving their goals, schools should not have them and the public should not be funding them.

Section Four
Other Criticisms of SBCs Emerge

In addition to the abortion connection, undermining of parents, and failure to demonstrate effectiveness on teen pregnancies, citizens groups all over the country have raised other objections which have, in some cases, stopped the establishment of SBCs.

First, critics charge, SBC's are extremely expensive in comparison with other health facilities--from $100 to $125 per patient per year, or from $80,000 to $100,000 per school (Kirby 1985, 15; Hurley 1986, C1; Ahartz 1986, 100-101). Moreover, physicians contend that there are much more cost-effective--and less controversial--ways to deliver health care to inner-city teenagers (Zanga 1986; Dryfoos 1985, 75).

Second, many people fail to recognize the necessity for eventual government funding for these costly SBCs after private funding runs out after a few years (Dryfoos 1985, 73).

Third, the public needs to be aware of the possibility that despite the assurances of the SBC proponents to the contrary, the school district and city government will be ultimately responsible for paying medical liability lawsuits (Lovick 1987).

Fourth, the U.S. Secretary of Education and many local school board members have voiced concerns that the SBCs will divert vitally important resources away from the already overburdened school system. (Bennett 1986; Raspberry 1986; Cook 1986; Reynolds 1986; Richburg 1986).

Fifth, Black leaders have attacked the racist attitudes in targetting SBCs almost exclusively in inner-city Black and other minority-dominated city schools (Allegar 1986; Shipp 1985; Associated Press 1986; Mount 1986). For example, in TIME magazine , Reverend Hiram Crawford, head of a group of Black ministers, parents and students who have filed a lawsuit against the SBC in the DuSable High School in south Chicago, asked "If these clinics are so good for black kids, why don't they put them in white areas?" "It's a

form of genocide," he continued. "Why do they so readily recommend abortion?" (Leo 1986, 58).

CONCLUSION

In view of the foregoing, the National Right to Life Committee will oppose any effort to involve the federal government in school-based health clinics unless these problems are resolved in the authorizing legislation.

S. 1366 would authorize the use of Title X funds in school-based clinics. Under the Title X guidelines, these clinics would be required to provide confidential abortion counseling and referrals. The National Right to Life Committee opposes the introduction of abortion services in this nation's high schools.

Notes

[1]According to the booklet titled "School-Based Clinics: Update 1986" published in October 1986 by the Center for Population Options, Title X provided approximately 3% of the income for SBCs that year (Lovick 1986, 13). Judging from that figure, SBCs are currently receiving only a fraction of the national Title X budget of $130 million. This assessment is consistent with a survey in 1986 conducted by the U.S. General Accounting Office. Only one of the eighteen SBCs that responded to the questionnaire received Title X funds. (United States, U.S. Government Accounting Office, letter HR6-147, Richard L.Fogel, Asst. Comptroller General, to U.S. Senator Jesse Helms, December 22, 1986)

[2]"Clinic News" 2:3 (October 1986), p. 3. Table titled: "States and Minor's Consent." "In 12 states where minors [definition varies] have the right to consent to their own medical care:" AL, AR, LA, MA, MI, MN, NV, NH, OH, RI, SC, WA. "Thirty-three states and the District of Columbia allow minors [definition varies] to consent to get contraceptives [and probably abortion counseling and referrals]: AL, AK, AR, CA, CO, DE, DC, FL, GA, HI, ID, IL, KY, LA, ME, MA, MI, MN, MS, MT, NV, NH, NM, NY, NC, OH, OR, RI, SC, TN, TX, VA, and WA.

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The CHAIRMAN. Senator Rees.

Mr. REES. Thank you, Senator Kennedy. I am pleased to be here and appreciate the invitation. I chair the Utah Senate health committee and I think I have a small understanding of the difficulty of these kinds of hearings and the anguish that you go through in trying to make decisions to help the young people in our country and those affected by title X.

The CHAIRMAN. Where is your district, Senator?

Mr. REES. It is in the Salt Lake area.

I might say that despite all the news coverage, Senator Hatch speaks very highly of you and your staff, but only in private. [Laughter.]

The CHAIRMAN. We get along well.

Mr. REES. I think I feel a little bit like a businessman that I met with a couple of months ago. He was very successful; he started out with nothing. His name is Al Thrasher. He invented a saw that sawed lumber 30 percent more efficiently than any saw had ever done in the past.

Of course, he made hundreds of millions of dollars. He has a foundation now where he spends most of his time trying to give his money away. I asked him what the key to his success was and he said, I look at what everybody else is doing and then I do it differently.

I think that we feel somewhat the same on this particular issue. We look at the efforts that have been made in the past in title X in the family planning area. We try to look at the research and we try to measure the results, and we see that maybe there are some results and there may be some impact, but it seems so slight that it is hard to measure and there is a lot of debate as to whether there really is any impact or not.

So we say in our own minds if we are going to have a significant impact, if we are going to come up with a program that makes a 10-percent impact or a 20-percent impact or even a 30-percent impact—and would it not be nice if we could do that because we know of the billions of dollars in welfare costs? We know that teen pregnancy is the number one contributor to the poverty cycle.

There are just so many reasons why it would be nice if we could come up with something that has a better impact than what we are doing right now, and that is what we are trying to do.

We have formed a task force in our State through the senate by statute that brings together the top officials in the State, the director of the department of health, director of the department of social services, director of the State board of education. I have been asked to be on the committee, and a number of the other officials in the State.

We are trying to address the problem in a more comprehensive, coordinated effort than we ever have before where we can really focus in on the problem. I am pleased to report to you that these top officials have been attending every meeting. It is a high priority to them, a top priority, very important to them.

We are doing our research now and we suspect that we will come up with something that is maybe a little more comprehensive than what we have been doing in the past. We feel like our approach in the past, although well intentioned, and we are doing the best we

can, we feel that maybe it has been kind of one-dimensional, the contraceptive approach.

We feel that there are a lot more factors involved than just contraception in order to help prevent teen pregnancy. We are convinced that there are a lot of other factors. We need to have other organizations involved, volunteer organizations, church support systems, parental support.

I guess we especially feel strongly about the need for parental support and parental involvement in any of our programs. You and I both know from appropriating money and trying to help improve programs to help people—I think we realize that the government makes a very poor parent, and I think schools make a poor parent and churches make a poor parent.

You know, no one can really take the place of a parent. There are a lot of needs in society going unmet and they will continue to go unmet until parents realize and take the brunt of those responsibilities, and that is what we feel needs to be done.

We feel that an integral part of any program that we adopt will involve the parents more than they are involved now, and will help parents realize their role in communicating with their children; maybe some type of curriculum that helps parents to dialog with their children.

We do not know where this work is going to lead us, but we are trying to approach it in a scientific way and we are trying to be pragmatic and practical about it, and we hope that we come up with a program that will be a lot more successful involving the whole family.

The thing that we would plead with from you is that we be given some flexibility. I just returned from Indianapolis where I am a delegate to the health committee of the National Conference of State Legislators, and the theme throughout that meeting and throughout all those meetings was to urge Congress to give the legislatures flexibility in dealing with their own problems.

We certainly feel the need to have flexibility in dealing with our problems. I cannot imagine any group that would oppose our request for a waiver because I feel like there are pockets of areas, especially some of the rural areas, that are not being serviced at all in our State because we have not been able to receive the Federal moneys.

So I just cannot imagine that anyone would oppose our waiver, especially if they are trying to help the young people. If they have a commitment to family planning, they would not be opposed to those extra funds coming to our State so that we could service the needs and meet some of the needs that are not being met at this time. So that is what we would ask for is your consideration in this one area.

The CHAIRMAN. Thank you very much, Senator. I have instructed staff to send you our teenage pregnancy legislation. We passed that 10 years ago before there were a lot of those who were really talking about teenage pregnancy. We took action on it; but it is a very limited program.

We are soon going to be reauthorizing that program. It is related, but also separate from what we are talking about here today. Many of the things which you have mentioned in your commentary

we understood were very useful and important in addressing those particular issues.

We will send you out that legislation, and hopefully you can give us comments because you have obviously given a good deal of thought and attention to the issue.

I will watch the time. We will take 10 minutes of questions.

I am not familiar with the institute for which you work or who funds it or what its relationship with Brigham Young University is. Could you tell us a little bit about it?

Mr. WEED. Sure. Myself and two other fellows started this institute 2 years ago as a private, non-profit group interested in adolescent issues. We have received and continue to seek funding from private and public sources and agencies, grant foundations, State and Federal agencies, and they are able to make those contributions under the 501(c)(3) stipulations.

We are not connected with Brigham Young University, with the Mormon Church, or anybody else. It is a private, non-profit enterprise.

The CHAIRMAN. So just roughly what is the budget of the institute and where do you raise it?

Mr. WEED. There are five people involved full-time. Other people do things on a contract basis. Our annual budget would be fairly small, certainly under $100,000.

The CHAIRMAN. And you have no relationship, then, with Brigham Young University?

Mr. WEED. Well, I have an appointment there on their advisory board for another organization, but I am not a faculty member or affiliated in any way, no.

The CHAIRMAN. The institute is in no way affiliated with Brigham Young?

Mr. WEED. No.

The CHAIRMAN. During the period of your study, the national pregnancy rates were increasing among young women. Was this trend controlled for in your study?

Mr. WEED. The national pregnancy rates were increasing among young women?

The CHAIRMAN. Increasing, nationwide.

Mr. WEED. That is right. What we did was we looked at the State-by-State variation in the pregnancy rate and correlated that with the State-by-State variation in adolescent enrollment in family planning programs.

The CHAIRMAN. How did you take into consideration the projections of growth in teenage pregnancy of your study? Did you include those?

Mr. WEED. Growth in teenagers?

The CHAIRMAN. Teenage pregnancy.

Mr. WEED. Oh, sure, yes. We did this in several different ways. We analyzed it longitudinally as well as cross-sectionally, so we looked at the incremental increase each year in the proportion of teenagers that became pregnant, related that to the proportion of teenagers that were enrolled in family planning programs, and controlled simultaneously for race and education and social status and all the other variables that are also related to sexual activity and to teenage pregnancy.

The CHAIRMAN. Well, how were your projections included in your study?

Mr. WEED. I am not sure I understand the question.

The CHAIRMAN. Well, there were more teenage pregnancies last year.

Mr. WEED. Sure.

The CHAIRMAN. That has been a national phenomenon.

Mr. WEED. Yes.

The CHAIRMAN. So in looking at these questions you have to channel the growth in teenage pregnancy I would think, if your analysis is going to be thorough and complete.

Mr. WEED. Yes.

The CHAIRMAN. I am just wondering whether you did include those projections which we have seen as a national phenomena. If you did, I am interested in hearing what your own estimate was and how you included it.

Mr. WEED. The kind of analysis that we did does not rely on projections. It relies on a State-by-State comparison. It is called a multiple-aerial regression analysis, and it compares the change in States over time with other States over time. So it does build in any changes from one year to the next in the teenage pregnancy rate.

The CHAIRMAN. Well, as I understand it, and I am just interested in your comments, there have been several peer reviewers of your research who have raised questions about the methodology. I do not know whether you are familiar with those or what comments you would like to make about them.

Mr. WEED. There have been questions made. This is not a popular kind of finding. When it flies in the face of a national program that has received considerable funding for 15 years, you are not going to make everybody happy, but that was not our intent. We simply wanted to find out what were the real effects, and this data will stand up under scrutiny; I am confident of that.

The kinds of questions that have been raised—the most important kind of question, I included in my testimony. It has to do with model specification. What that means to researchers is perhaps there is some other variable that was not included in the analysis, and if it were included it would change the pattern of results.

We included every variable that was available to us, and the pattern does not change. We looked at prior fertility, we looked at sexual activity, we looked at abortion availability, every variable that is available on a State basis, and the pattern just sits there.

The abortion rate is higher, the birth rate is lower, and the pregnancy rate is moderately higher in every case. In addition to that, we looked at data from different sources, we looked at data from different time period. We did every different kind of analysis that researchers know how to do, and the pattern keeps showing up.

It is a solid finding; it is not going to go away. Somehow, we need to explain it. I have some ideas, but we are still doing the research that would test the theories that explain the findings.

I know that is disturbing. Even the questions about parental consent and parental notification presuppose that if kids have greater access and greater availability to contraceptives, the pregnancy rate will go down, and that simply is not the fact.

The CHAIRMAN. Well, one of the points that was made in reviewing your own study is that you contrast pregnancy rates among women receiving family planning services with rates among those who do not.

How do you respond to the charge that women who seek out family planning are likely to be more sexually active than those who do not?

Mr. WEED. Our analysis takes into account the total population and looks at the proportion of them that are involved in family planning programs, so that question is not relevant to the analysis that we did.

The CHAIRMAN. Well, I am not so sure that can be so easily dismissed. I mean, I remember when we were examining some of the studies on cancer and cancer research. We were told that at one time the use of silk stockings was thought to cause lung cancer because the occurrence of both increased at similar rates, and yet it had absolutely nothing to do with anything.

Mr. WEED. Sure, yes. That question came up in another setting. They used fire engines as an analogy, and another group used fluorides in the water. But what we did—if you did not include the other control variables that we did, the relationship between family planning programs and teenage pregnancy rates is in the neighborhood of 0.61—extremely high. When you put all the control variables in, it is .042—still positive in the wrong direction.

So by including all the other kinds of control variables, you end up with a relationship that is stable and consistent and robust over time and over different data sets. It just will not go away.

Believe me, we have tried every way we can to make that disappear. You have to assume when you do this kind of analysis that you have a spurious relationship and you try to find the basis for that inconsistency, that spuriousness in your relationship. It just is not there.

The CHAIRMAN. Ms. Gasper, you stated that DHHS has not administered the title X statute properly for 17 years through three Republican and one Democratic administration. During this time, Congress agreed with the Department's management by passing five reauthorizations of the statute without directing DHHS to change its management.

Why now should your interpretation be deemed correct?

Ms. GASPER. With all due respect, Senator Kennedy, I do not believe that Congress was aware of the difficulties in the title X program until the General Accounting Office did a thorough investigation in 1982, and at that point in time the difficulties in the administration of the program were clearly documented.

As you are very much aware, the reauthorization of title X has been somewhat rocky in the last several years.

The CHAIRMAN. Well, I will just reference in the report that there were GAO studies that were done and other studies that were available to Congress and they did not reach the same conclusion. I will just reference those and put them as part of the record.

[Information supplied follows:]

Re: Dates of Heckler and Bowen testimony on Title X

9/23/87

1984

In hearings before the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce, April 3, 1984, Secretary Heckler testified that, "... the family planning clinics have been very aware and have honored the law in terms of the abortion prohibition..."

(Committee on Energy and Commerce hearing record, 98-121, p. 472)

1985

In hearings before the Subcommittee on Health and the Environment, March 27, 1985, the Acting Assistant Secretary for Health, James Mason, in response to a question, confirmed that Title X grantees were in compliance with the law.

(Committee on Energy and Commerce hearing record 99-13, p. 189)

1986

In hearings before the House Appropriations Committee Subcommittee on Labor-HHS-Education, Secretary Bowen, in response to a question, said that there has never been any evidence of noncompliance with the law by Title X grantees. February 18, 1986.

The CHAIRMAN. Do you have any substantive evidence that family planning agencies routinely and in a material way subsidize abortion with their Federal funds?

Ms. GASPER. Apparently, you have read my testimony, and I think if people will think about the example which is in there of a co-sited family planning and abortion clinic where you have a family planning clinic that is operated on Monday, Wednesday and Friday—on Tuesday and Thursday you have an abortion clinic; the husband does the abortions and is the head of one organization, and the wife is the head of the other organization. You have shared space, you have shared staff, you have identical waiting rooms, identical clinic files.

The indirect costs are shared on a proportional basis. I think most people are very much aware that the cost of such things as insurance for malpractice, property damage and liability are higher for more risky procedures. Abortion clearly is a much more risky procedure than the normal sorts of family planning services provided by title X.

So, yes, because of the accounting mechanisms, title X dollars are subsidizing and reducing the costs to the abortion clinics.

The CHAIRMAN. Is there separate accounting required for expenses for each of those particular functions?

Ms. GASPER. There may be a mechanical accounting, and what I have said in my testimony is using the example where you have a proportional share or percentage share of the expenses based upon the number of days of service, that is not an accurate reflection on the cost of the services being provided; that the title X clinic does, in fact, underwrite the expenses of the abortion clinic.

It would be much more expensive for the abortion clinic to go off and have to find its own space, its own doctor, and to be in a shared capacity. Furthermore, the title X program is able to—I guess in marketing terms we would call it function as a loss leader, drawing clientele in and the people who would be using the abortion services.

In fact, when you look at what happens as far as the abortion referrals between public clinics and Planned Parenthood clinics, although the average abortion referral rate from a public-based title X grantee is 10.2 percent, the average referral rate from Planned Parenthood is 35.2.

If you look at the referrals from public clinics, the highest is 20 percent, and if you look at the highest abortion referral rate from a Planned Parenthood clinic, it is 86.4.

I think that clearly indicates that having the co-location of organizations that are engaged in abortion advocacy and operations does support abortion.

The CHAIRMAN. Well, I think for the record we ought to include both the Inspector General audits and the studies done by the DHHS office which do not support those conclusions. As a matter of fact, in looking over the IG audit there was only one instance where there was any question about malpractice insurance.

[Information supplied follows:]

Comptroller General. "Restrictions On Abortion And Lobbying Activities In Family Planning Programs Need Clarification." General Accounting Office, (GAO/HRD-82-106), September 24, 1982.

Kusserow, Richard P. "Review of PHS Title X Family Planning Grantees—Audit Control No. 12-33177." Department of Health and Human Services. November 18, 1982

The CHAIRMAN. In testimony before the House Subcommittee on Health and Environment in both 1984 and 1985, and again in testimony before House Appropriations on Labor, HHS and Education in 1987, former DHHS Secretary Heckler and DHHS Secretary Bowen specifically affirmed that clinics are in full compliance with the prohibition.

Ms. GASPER. Well, as I state in my testimony, it is through bureaucratic manipulation that the Department is able to say that the program is in full compliance because of the way the statutory language is and the way the Department has administered it. We only look at projects, and if you are looking only at projects, it becomes a tautology.

The CHAIRMAN. Well, I think Dr. Bowen, who is a physician, is very clear, and his testimony as well as Secretary Heckler's, I think, is quite compelling to the contrary, and I would just reference those for the record.

Mr. Glasow, although this is a hearing on title X, I thank you for extensive testimony on the school-based health clinics. Is it not true that there may be only one school-based clinic in the country which receives title X funding?

Mr. GLASOW. My understanding from information provided by one of the organizations promoting school-based clinics is that three percent of the funding as of August 1986 was provided by title X.

The CHAIRMAN. Can you supply it? Can you tell us what those school districts are?

Mr. GLASOW. It was School-Based Clinic Update, 1986, published by the Center for Population Options.

The CHAIRMAN. But do you know which schools are included?

Mr. GLASOW. No. That was not available in the document that I had. I acknowledged in my testimony that the number is small now, but the school clinics are desperate for money. This is a very lucrative way to get more money, have it available through title X, and they like title X because it will allow them to impose the federal guidelines requiring abortion counseling and referral onto the school setting, and that is our problem with it.

The CHAIRMAN. Do you agree that the decision to open a school-based clinic should lie with the local school board rather than with the provisions in federal legislation?

Mr. GLASOW. Yes, I completely agree with that. In fact, I would prefer that the local communities have the decision because it will prevent problems like we have with title X of forcing them to do things that they do not want to do, like abortion counseling and referral.

What we are afraid of, Senator, is that if a clinic gets title X—let us say a clinic gets opened and then gets title X funds and the school board has said no counseling. title X will impose a Federal law on them or a Federal guideline and they will not have any choice.

The CHAIRMAN. Well, they can make the choice and decision whether they want to make those applications in the first place, can they not?

Mr. GLASOW. Yes, but the way that the clinics are being portrayed right now is they are saying, look, we are not going to do abortion counseling and referral. That is very misleading because they do do it, but indirectly.

Then what happens if they get title X money subsequently and then the school board is faced with a very difficult decision? Do they turn off the clinic and shut it down after it has established a lot of momentum and cause a lot of problems for some of the kids, or do they acknowledge that they have to live up to the Federal guidelines and, in other words, swallow what the Federal Government forces them to do?

I think that they should have the right to make their own decisions without the Federal Government forcing them to do it.

The CHAIRMAN. No one is forcing them to take the money, are they?

Mr. GLASOW. Well, that is just the point.

The CHAIRMAN. They do not have to take it. I mean, you cannot have it both ways and say, well, I will take the money and, oh, dear, I have to live with that requirement.

Mr. GLASOW. Well, the majority of the clinics, sir, are operated by entities outside of the school system; they turn it over. For instance, the Ounce of Prevention Fund in Chicago is a good example.

If they decide to get title X funds, the school board has already given the authority to operate the clinic. They have just given them the space, and then the Ounce of Prevention Fund—this might not be a good example, but they are an outside organization and nonprofit. They get the title X funds and then the school board is stuck.

The CHAIRMAN. Are you aware of the Hopkins study that found that the onset of sexual activity among teenagers was delayed by access to the services provided in title X?

Mr. GLASOW. Yes, sir, and we think that the methodology of that study undercuts everything that it supposedly shows.

The CHAIRMAN. I see.

Mr. GLASOW. My testimony alludes to that and I can provide more documentation if you wish.

The CHAIRMAN. His methodology is okay, but Johns Hopkins' is not.

Mr. GLASOW. No, sir. I am saying that the methodological problems—they are comparing apples and oranges, two different kinds of schools. They tried to do a survey of two different sets of children before and after the study was started. There are a lot of serious problems that have been raised.

The researchers refused to give the numbers as opposed to percentages. There are a lot of serious questions raised. The other major issue is should policies all over the United States be based on one study. I think not.

Ms. GASPER. If I could kind of follow up on Mr. Glasow's comment regarding the Hopkins study, the finding regarding reduced

sexual activity rates would be much more compelling if the Hopkins folks had looked at contemporaneous sexual activity rates.

Instead, what they did is they looked at the rates in one time frame and then several years later looked at it again. What we know nationally is during that time period that they were looking at, there was a national decline in sexual activity rates among adolescents.

Therefore, one does not know whether what was happening in the Baltimore school system was a reflection of what was happening nationally or what was actually happening in the school. Therefore, the sexual activity decline is not—you know, it is a questionable finding.

The CHAIRMAN. Did you take those into consideration, Mr. Weed?

Mr. WEED. Yes. I am familiar with the Hopkins study as well and as has been pointed out, the sample of girls for whom the pregnancy rate was computed—that is, the 30-percent reduction in the pregnancy rate that has been claimed—is based on 96 girls who were in the program for 2½ years.

Now, the pregnancy rate among those 96 girls would require only a difference of four or five pregnancies to come up with the 30-percent reduction. Four or five pregnancies in a population of 96 girls could be accomplished by two sexually active boys dropping out of school and not being involved with those girls. So I do not have a lot of confidence in those findings.

The CHAIRMAN. What was that again? [Laughter.]

Mr. WEED. I was being a little bit facetious. What I am saying is that the 96 girls upon which that 30-percent reduction was based is not a large enough sample to base any national policy on.

Our study, on the other hand, is based on all 50 States over a 6-year time period and gives careful consideration to the broad policy implications that the Johns Hopkins study cannot address.

The CHAIRMAN. Senator Humphrey.

Senator HUMPHREY. Thank you, Mr. Chairman. First, my thanks to you for holding this hearing. It has been some years, as I understand it, since the Senate has had hearings on title X.

While the program has been reauthorized over the years, it has been really quite some time since it was reauthorized in the usual manner. I think it has been appropriated in the CR in recent years. It would be nice if we could deal with it in a regular manner. This is the way you begin, and I thank the chairman for doing that.

Now, having complimented him, how much time do I have for questions?

The CHAIRMAN. We have another panel. Ten minutes is what we were looking at.

Senator HUMPHREY. I wanted to begin with——

The CHAIRMAN. Senator Mikulski will be coming at 3:30. They are doing a classified briefing on Panama which Senators have been invited to which started at 2:30. I am going to have to absent myself when she comes over.

But depending on her time, I wanted to keep the hearing moving along. We have got a third panel, but if she wants to spend more time, I do not want to interrupt the Senator from New Hampshire. Why do you not just proceed and we will try and accommodate whatever time the Senator needs?

Senator HUMPHREY. Thank you.

I want to begin with Mrs. Gasper. I wish you could have been at the White House this morning.

Mrs. GASPER. I understand it was quite a thrilling event.

Senator HUMPHREY. Well, it was not billed as such, but this was Jo Ann Gasper Day at the White House, and today, by the actions of the President, courage and principle won out over timidity and expediency. Jo Ann Gasper won out over the DHHS bureaucracy. She had to sacrifice a good deal for that, but let me assure you it was worth it because the President of the United States has exonerated you today by his actions.

Mr. Chairman, I was not here when the hearing commenced. I would ask to put a prepared statement in the record.

The CHAIRMAN. It will be so included.

[The prepared statement of Senator Humphrey follows:]

STATEMENT OF SENATOR GORDON J. HUMPHREY

HEARING ON S. 1366
COMMITTEE ON LABOR AND HUMAN RESOURCES

JULY 30, 1987

MADAME CHAIRMAN: I APPRECIATE THE OPPORTUNITY TODAY TO EXAMINE S.1366, A FOUR-YEAR REAUTHORIZATION OF TITLE X OF THE PUBLIC HEALTH SERVICE ACT.

THIS PROGRAM HAS SEEN A GREAT AMOUNT OF CONTROVERSY OVER ITS SEVENTEEN-YEAR HISTORY. FROM ITS INCEPTION IN 1970, PUBLIC DEBATE RAGED OVER THE FAMILY PLANNING ASPECTS OF THE PROGRAM. ONLY A FEW SHORT YEARS EARLIER THE SUPREME COURT IN ITS GRISWOLD DECISION HAD EFFECTIVELY ENSURED THAT CITIZENS WOULD BE FREE TO PURCHASE CONTRACEPTIVES.

IN ADDITION, PUBLIC DEBATE FOCUSED ON POTENTIAL ABORTION INVOLVEMENT WITH THE NATION'S FAMILY PLANNING PROGRAM. WHILE ABORTION WAS NOT LEGALLY AVAILABLE ON DEMAND IN ANY STATE, OPPONENTS AND PROPONENTS OF THE BILL INTENDED TO ENSURE THAT ABORTION WAS NOT PROMOTED IN ANY WAY BY TITLE X.

SEVENTEEN YEARS LATER, CONGRESS IS AGAIN REVIEWING THE NATIONAL FAMILY PLANNING PROGRAM. IT SEEMS THAT THE DEBATE OVER CONTRACEPTIVE METHODS OF FAMILY PLANNING HAS WANED. BUT THE DEBATE OVER ABORTION, HAS, IF ANYTHING, DEEPENED AND BECOME MORE PROMINENT. ABORTION HAS COME TO PLAY A FAR GREATER ROLE IN TITLE X THAN ENVISIONED BY ITS AUTHORS. AND WITH THAT GREATER ROLE HAS COME GREATER CONTROVERSY -- TO THE ULTIMATE DETRIMENT OF THE FAMILY PLANNING PROGRAM ITSELF.

TITLE X HAS NOT BEEN REAUTHORIZED IN YEARS AS A DIRECT RESULT OF THESE ABORTION CONCERNS. THE HOUSE HAS ANNUALLY REJECTED REAUTHORIZATIONS ON VOTES TO SUSPEND THE RULES. THE HOUSE REFUSES TO APPROVE STRAIGHT REAUTHORIZATIONS WITHOUT THE OPPORTUNITY TO ADDRESS ABORTION AND PARENTAL CONSENT CONCERNS.

THE SENATE HAS BEEN UNABLE TO BRING THE BILL TO THE FLOOR FOR A VOTE FOR SIMILAR REASONS. WHEN FACED WITH THE OMINOUS SPECTER OF VOTING ON ABORTION AND SCHOOL-BASED CLINICS ISSUES, THE LEADERSHIP HAS PREFERRED TO FUND TITLE X THROUGH CONTINUING RESOLUTIONS.

THE ABORTION CONCERNS OF SO MANY MEMBERS OF CONGRESS, ARE NOT THE VAGUE, IMAGINARY CREATIONS OF MINDS BRIMMING WITH FEARS ABOUT CONTRACEPTIVES AND ABOUT SEXUALITY IN GENERAL. RATHER, THE ABORTION CONCERNS ARE ROOTED IN WELL-DOCUMENTED VIOLATIONS OF PLAIN STATUTORY AND REGULATORY LANGUAGE.

INDEED, BEYOND ABORTION CONCERNS ARE NEW CONCERNS, RAISED FOR VIRTUALLY THE FIRST TIME IN THIS PROGRAM BY THIS BILL. THESE CONCERNS INCLUDE THE PROMOTION OF NON-SURGICAL, CHEMICAL ABORTION; THEY CONCERN THE PROMOTION OF FAMILY PLANNING ACTIVITIES IN SCHOOLS AMONG ADOLESCENTS; AND THEY CONCERN THE RELATIVE ABSENCE OF ADOPTION AS AN ALTERNATIVE.

I ASK THAT THE BALANCE OF MY REMARKS BE INSERTED IN THE RECORD AS IF READ.

Senator HUMPHREY. Once more for the record of this hearing, Mrs. Gasper, will you state where you felt the Department was in error in administering the title X program in a way that you felt was contrary to legislative intent?

Mrs. GASPER. There are several areas where the program has not been operated in strict conformance with law. One area is the funding of abortion advocacy organizations, which is clearly questionable under the law.

As I said earlier, abortion is antithetical to the family planning program.

Senator HUMPHREY. Why is that?

Mrs. GASPER. Because of the statutory basis. It says none of the funds appropriated under this program may be used in programs where abortion is a method of family planning. The Office of General Counsel of the Department of Health and Human Services has stated that the language is the basis for abortion being antithetical to the title X program.

When title X was originally discussed and debated, there was a lot of concern about abortion, and it was quite clear from the Congressional Record and the debates that Congress did not want the title X program to promote, encourage, or advocate abortion.

So there is no question that abortion is—I mean, after all, the reason you have family planning is to help women to either not get pregnant or to have healthy pregnancies and healthy babies once they become pregnant. Abortion does not belong.

There is a Department rule that was established back in roughly 1976 or 1977 that has basically been ignored by the Department that calls into question the funding of advocacy organizations that hold views that conflict with the statute. Abortion is clearly in conflict with title X, and the funding of abortion advocacy organizations is questionable, and we are talking about the totality of the organization and not just what is defined in the project.

When I attempted to follow the normal administrative procedures to review, that permission was denied, and that led up to the two Planned Parenthood grants lapsing. There was a Department rule that prevented the funding of lapsed grants.

The Department ordered me to violate that rule, and for six times, ending with telling the Secretary—I explained that I could not, because it was unlawful, inappropriate, and contrary to my moral convictions, fund those two grantees.

That is one concrete example of where the Department has not followed its own rules.

The co-siting of abortion clinics and family planning clearly is contrary to the statute. The way the Department has defined "program" in such a way as to basically permit anything is outrageous.

What the Department has done is defined "program" to be a project; in other words, what is in the four corners of the grant application. Anything an organization does or a program does outside of those four corners is not covered, and that is clearly not what people think of when they mean program.

I am sure Senator Kennedy and you, Senator Humphrey, when you go to the YMCA, as an example, when you walk through those doors, you think of what happens in those facilities as being the program, the YMCA.

Under HHS rules, that is not the way it is operated. Only that part which is paid for by title X is declared to be title X, and I think that is clearly inconsistent with the statute.

Senator HUMPHREY. I assume that given all that you have been through that you have tried to discern for your part the legislative intent. As you noted, there was a good deal of concern about abortion.

In your reading of legislative intent, why were Members of Congress concerned about abortion in the context of family planning?

Mrs. GASPER. Because of the—remember, it was back in 1970. Contraceptives were just beginning to be commonplace, if you will. We were moving from an age where to get contraceptives you were only permitted to provide contraceptives to married individuals. Abortion was illegal, a State's rights issue at that point in time.

There was a great concern as to whether or not providing family planning services would, in fact, increase abortions, would result in increased referrals to abortion, would permit abortion being used as a backup for contraceptive failures.

The contraceptive field, as we know it, has changed significantly since the 1970's to today, and people who passed title X wanted it to be a preventive family planning program and not a program that kills unborn children.

Senator HUMPHREY. Well, that is the important distinction, or so it seems to this Senator, that family planning—and I believe it was the intent at the time—that family planning was to be preventive in nature. Taking the life of a child already conceived can hardly be viewed as preventive.

It was not viewed as a preventive measure in those days, was it, according to your reading?

Mrs. GASPER. No. Abortion is clearly not a contraceptive. It is using abortion as a search and destroy mission that takes the life of an unborn child.

Senator HUMPHREY. And because of the very special nature of abortion that it takes the life of a prenatal infant distinguishes it dramatically from legitimate methods of family planning?

Mrs. GASPER. Very much so.

Senator HUMPHREY. Therefore, federal funds that are devoted to providing family planning in no way should be tainted by association with organizations that advocate or perform this procedure which kills a human being.

Mrs. GASPER. I think you are quite right. As I said earlier, I think that that tainting by funding pro-abortion organizations acts to the detriment of what otherwise could be a very fine program.

Title X does provide some very valuable services. It does help improve health care for low-income persons. It can be the first point of contact for women into the health care delivery system, and all that is very good and I do not think there is any controversy on those kinds of services or on title X helping people have healthy pregnancies and healthy babies or finding babies through adoption or infertility services.

It is when we get to the tainting and the abortion issue where the consensus falls very much apart. By having the abortion subsidies and the promotion and the advocacy and the tainting in the

title X program, it questions what is otherwise a good and respectable program.

Senator HUMPHREY. Well, you do not question, do you, the right of organizations—in the abstract, the right of organizations to advocate abortions? You are contending, however, that no such organizations should be supported in any way by federal funds?

Mrs. GASPER. Under the title X statute, they are ineligible for funds and it has nothing whatsoever to do with their constitutionally-protected rights of free speech, nor does it deny the recipients of title X funds access to legal options.

Senator HUMPHREY. Yes.

Mr. GASPER. All we are saying, and it is a strongly and long-held principle, is that taxpayer money should not go to those kinds of activities. Even when you have a constitutionally-guaranteed right, there is no requirement that the taxpayers have to finance the exercise of that right.

Senator HUMPHREY. Of course, you and I understand this. In a sense, those are rhetorical questions, but I think the public might not always understand that when they hear us complaining about certain uses of family planning money, they think we are against family planning, per se, and that is not your position, is that right?

Mrs. GASPER. No. Family planning is very valuable, and I am talking about family planning as preventive family planning services. I am not talking about abortion. I am talking about assisting people to have children, to become pregnant, to plan their having their family, not to plan their killing their family.

Senator HUMPHREY. It is very much like the controversy over Federal funding of abortion under Medicaid or other programs, which has been cut off annually by the Hyde amendment, the rationale of the Hyde amendment being that, yes, a women has a right under the Supreme Court's decision of 1973 to secure an abortion, but the taxpayers have no obligation to subsidize the exercise of that right.

Mrs. GASPER. That is correct.

Senator HUMPHREY. And just as organizations have a right to advocate abortion, it does not follow that taxpayers are required to subsidize the exercise of that right, and that I think is the essential point that needs to be made by those of us who have grave concerns about title X as it has been administered or, in our view, maladministered by HHS.

The taxpayers are being forced to subsidize organizations that counsel and refer women for abortion, and there is no constitutional mandate—nothing requires the taxpayers to subsidize such activities, even though such activities are well within the "rights" of those who engage in them. That is the point of distinction. I think sometimes you cannot state the obvious often enough, especially in Washington where things get overly complicated sometimes.

I want to talk now in the few minutes I have remaining about the failure or reputed failure of the Department of HHS to examine grantees or applicants which seem to fit the description of an exceptional organization.

Will you talk a little bit about that, again, so the public will understand what this controversy is about? What is an exceptional or-

ganization, and what actions are required by HHS in dealing with such organizations?

Mrs. GASPER. Under the Department rules, an exceptional organization can be exceptional for one of two reasons, because of business practice or because of its advocacy activity.

In the title X program, the real issue is the advocacy activity and, in particular, abortion advocacy because under the rules if an organization advocates a position which is at conflict with statute, there are special risks associated with funding that organization.

Clearly, proabortion advocacy organizations fall under the rule of what exceptional organizations are. The rules talk about positions which are religious, political, and morally sensitive, and I think abortion is both political and morally sensitive, so it meets all of the requirements for having the rules applicable.

Under the rules, organizations are supposed to be reviewed to make sure certain things do not happen, and some of those things are—and it is not restricted to just what is in the rules, but the things that the rules specify are that a cause is advanced or strengthened that is at conflict with the statute. Clearly, funding an abortion advocacy organization strengthens abortion advocacy, and that is at conflict with the statute.

Persons who are vulnerable will be put in a special relationship, and what we are talking about there is people will be under, shall we say, some pressure in that the direction that they are being pressured in will be derived based on a commitment to something other than what the statute is.

I think that clearly is a problem in title X where you have young girls going into counseling with counselors who are in favor of abortion. In fact, I have pointed out that Planned Parenthood—I mean, 86.4 percent of the cases looked at in one clinic were referred to abortion. That clearly cannot be—I mean, it is hard to imagine that that is all life of the mother.

The organizations in their operations will not—not because they intend to do something unlawful, but because of their biases—will not review things properly. So those are some of the concerns that are raised in the grants rules, and the grants rules require looking at organizations to see if any of the problems may arise and taking certain actions.

Those actions range from deferring funding, providing technical assistance, issuing grant conditions, or not funding the organization.

Senator HUMPHREY. How many years were you at HHS?

Mrs. GASPER. A total of—let us see; it would have been 6 years in November of 1987.

Senator HUMPHREY. During that period of time, how would you rate——

Mrs. GASPER. 1988, pardon me; November of 1988, it would have been 6 years.

Senator HUMPHREY. How would you rate the performance of HHS in enforcing the exceptional organization regulations during your tenure there?

Mrs. GASPER. I can speak to the title X issue, and they have not done so. They have used the regulations in the past. The regulations were brought to my attention by the Department lawyers.

That there has been a problem in the administration of the program, I think, goes back to the days when I was asked to become the DASPA. When I met with Secretary Heckler then, she clearly told me she was a strong advocate of family planning, was an ardent opponent of abortion, and that the program needed to be cleaned up and fixed up, and we tried to do that.

Senator HUMPHREY. With respect to the administration of title X, did you just say that during your 6 years you were aware of no efforts to enforce those regulations?

Mrs. GASPER. I am aware of no efforts to enforce the exceptional organization rules in the title X program. In fact, when I attempted to do so and had discussions with the regional health administrators, I was told they only looked at the project; in other words, what is in the four corners of the grant application.

In discussions with the grants management experts at the Department, the rule clearly specifies you need to look at the organization, which is a broader thing. The regional health administrators told me that they had not and that they would not until they got explicit written instruction, and I was prevented from providing them explicit written instruction to follow DHHS rules.

Senator HUMPHREY. A pretty sorry record. I understand the Inspector General is conducting an investigation of that and allied matters, and the result of the report of that investigation as an independent investigation will be very interesting, I think.

There are a great many other questions I could ask, but we do have other panelists waiting. So, Mr. Chairman, if I may, I would like to reserve the right to submit further questions in writing to the witnesses.

While the chairman is occupied, let me just finally say that it is astounding to me that there should even be a debate on this point. I mean, this business of performing operations that remove from its mother womb by mechanical or chemical processes unborn human beings with the explicit intent of bringing their death is so gruesome, is such a grotesque violation of human rights that it is just astounding to me that we should even have to debate the point.

I understand that is a point of view shared by the chairman, and I would hope that he would at least entertain some of the amendments that will be forthcoming to this bill.

The CHAIRMAN. The fact remains that the kind of activity which the Senator has just described is prohibited by law at the present time.

Senator HUMPHREY. I beg your pardon?

The CHAIRMAN. Is prohibited by law under the existing program.

The testimony of the Inspector General and the testimony of Dr. Bowen, who is not known as being a figure who has been a wide supporter in terms of abortion—his testimony before the committee has been very clear as well that these activities are not taking place under this program.

The former Secretary of HHS from this administration has testified that those activities are not taking place. So one can conjure up all kinds of unfortunate activities or behaviors or conditions and deplore them. Those do not happen to be, on the best information that the various congressional committees have, the kind of activi-

ties which are taking place, and I think it is important that we understand that.

Under this program, title X, the effects of the program are clear and I believe the program should be continued. There is an estimated 800,000 unwanted pregnancies each year prevented through this program.

These programs also provide important prevention against infant mortality. When women can pace their pregnancies, the incidence of low birth weight and infant mortality is reduced. Women also receive vitally important prenatal counseling through this program, which also reduces the incidence of infant mortality. Many fetuses survive to full term and healthy lives because their mothers' pregnancies are properly seen through the prenatal period.

With these facts before them, the Institute of Medicine reminded us in their 1985 report, "Preventing Low Birth Weight," that family planning services should be an integral part of overall strategies to reduce the incidence of low birth weight in infants.

By reducing the number of unwanted pregnancies, family planning also prevents an estimated 400,000 abortions each year.

As I mentioned, by law, since the beginning of this program, no Federal funds provided under it may be used for abortion. The General Accounting Office and the Inspector General's Office have both policed this requirement, and Congress has been assured by Secretary Heckler and by Secretary Bowen that no title X funds are being used for abortion.

I asked the panelists whether they had any particular clinics where that was being done. They could not name any. They gave us circumstances that they thought led to that conclusion, but they were silent in being able to indicate where there might be those kinds of activities.

The administration does not seem to be listening to its own Cabinet officials and now, I believe, is grandstanding on this particular issue. The President's recent proposal is based on illusion and not on the facts.

The President has also proposed that doctors and other health providers at family planning clinics not be required to tell a woman all of her legally and medically available options.

The rules already forbid that abortion be advocated. The rules even prevent abortion from being favorably discussed. All this new rule would do is undermine a physician's duty to tell the truth.

So the bottom line is that the new rules are addressed to nonproblems in a program of proven worth, and we should, I believe, ignore these distractions and get on with the work of public health.

We are going to recess now and vote.

Senator HUMPHREY. Mr. Chairman, may I respond before you recess?

The CHAIRMAN. You can when you come back. I am going to go vote.

Senator HUMPHREY. I appreciate the courtesy.

[Recess.]

Senator MIKULSKI [presiding]. The Senate Labor and Human Resources Committee will reconvene. Senator Kennedy is at a Judiciary hearing on the Bork nomination, and I will be chairing panel three. We look forward to hearing our witnesses.

I understand we have Dr. Alton Cobb, who is the State health officer for the Mississippi State Department of Health; Scott Swirling, the executive director of the National Family Planning and Reproductive Health Association; and Diana Gurieva, the executive director of Planned Parenthood of Maryland.

Again, we apologize for the delays. It has been one of those busy days in the U.S. Senate. The Appropriations Committee is deciding on the marks we will have to spend, and foreign policy considerations and judiciary.

So having said that, Dr. Cobb, why do we not start off with you and then we will hear from Mr. Swirling and then you, Ms. Gurieva.

Dr. Cobb.

STATEMENTS OF ALTON B. COBB, DIRECTOR, MISSISSIPPI STATE DEPARTMENT OF HEALTH, JACKSON, MS; SCOTT R. SWIRLING, EXECUTIVE DIRECTOR, NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, INC., WASHINGTON, DC; AND DIANA GURIEVA, EXECUTIVE DIRECTOR, PLANNED PARENTHOOD OF MARYLAND, BALTIMORE, MD, ON BEHALF OF PLANNED PARENTHOOD FEDERATION OF AMERICA

Dr. COBB. Madam Chairman and distinguished members of the committee, I am Alton Cobb. I am director of the Mississippi State Department of Health. I am certainly delighted to have the opportunity to testify today regarding the reauthorization of title X of the Public Health Services Act and to describe what these services mean to Mississippi in our efforts to lower infant mortality, decrease dependency, and expand social and economic opportunities for our people.

Senator MIKULSKI. Dr. Cobb?

Dr. COBB. Yes.

Senator MIKULSKI. Do you see those little microphones? If you could move those to you as if they were a surgical mask, I think we would be able to have the benefit of your testimony.

Dr. COBB. If my bifocals will allow me that—I think they will.

Senator MIKULSKI. I have the same problem, but the Committee certainly wants to hear your testimony.

Dr. COBB. All right, fine.

Senator MIKULSKI. Please go ahead.

Dr. COBB. In Mississippi, the State Department of Health is the administering agency for the statewide family planning program. We do have subcontracts with community health centers, but between our agencies and the community health centers we are the sole providers of services funded under title X.

These services include confidential counseling; examinations, including cancer screening; education; and contraceptives. Additional special areas addressed by the program include the provision of surgical sterilizations to both high-risk men and women, and infertility services for persons who desire pregnancy.

In 1986, the State Family Planning Program in Mississippi served 97,314 unduplicated users, including 27,910 teenagers, at approximately 150 clinic sites throughout the State. Using nationally accepted evaluation indicators, the family planning program pre-

vented some 15,000 unwanted pregnancies in 1986 in our State. Of these, over 4,000 would have been pregnancies to teenagers.

Of the individuals served, 93 percent met the criteria of target population users, which is defined as adult women with incomes at or below 150 percent of poverty and sexually active teens.

While Mississippi is at or near the top among the States in relation to the percent of its target population served, services are not available to a significant number of targeted individuals due in part, at least, to inadequate program financing.

For fiscal year 1986, title X directly supported about 34 percent of our total family planning budget. Our total budget was a little over $9 million, and the title X funds amounted to $3.1 million. The remainder came from Medicaid fees, patient fees, social services block grant, and the maternal and child health block grant and State and local funds. About a third of our budget came from State and local funds.

Title X funding is essential in Mississippi and represents the primary source of family planning dollars in our State. Because Mississippi's average medical cost per user, which is about $100 per year per user, is well below that of the Nation, it is clear that the available funds are being used efficiently in Mississippi, and the only real need we have is more outreach and funding to serve additional persons in the target population.

In Mississippi, family planning is an essential component of an integrated system of care for mothers, infants and children, which includes delivery of State-wide prenatal, WIC, and child health services.

Significant strides have been made during the last quarter century in our State in reducing its infant mortality. In 1960, our infant mortality was 41 deaths per 1,000. In 1986, we are very pleased to report it is 12.3 and we are no longer number one in the Nation. There are several other States that now have infant mortality rates that exceed the rate in Mississippi.

Our race-specific infant mortality rate in 1986 was 8.9 for whites and 16.2 for blacks. Family planning services, especially those targeted to teens, have contributed, in our judgment, in major part to this reduction.

Clearly, any attempts to further reduce infant mortality in Mississippi must continue efforts toward substantial reduction in the teen pregnancy rate and further reductions in fertility rates in our low-income, high-risk population groups.

Our State leadership in our legislature has recognized the need for education, and more recently they have recognized the need to take major steps to improve our infant mortality through family planning programs and through a regionalized system of prenatal services and through improved access to prenatal care.

We, of course, follow the Federal guidelines. We provide the services under the Federal standards. We do not oppose the Federal standards. We would oppose any effort to mandate parental notification because we think that would be a detriment in our State, for many of our teens do not have stable families. They do not have family members that they could readily turn to for counseling. We think where there is a constructive family relationship that in-

volvement is present, and we do not believe that mandating it through law would add anything constructively.

Was that my time limit?

Senator MIKULSKI. It was, but the Chair notes that besides being proud of Mississippi comments, which we were sure that you would want to make, that you did want to say something about prevention.

Doctor, I think this is something we are quite eager to hear, so why do you not take those couple of sentences and tell us how terrific your State is and then wrap it up?

Dr. COBB. OK. One thing we have done recently is to target school nurses, public health nurses, in high-risk schools, schools that have high rates of teen pregnancy. These are not full-blown school-based clinics, but they represent for our State an opportunity to provide counseling, education and intervention in terms of referral for family planning services.

I can cite you one school. I do not have a lot of fancy statistics, but the year before we started this program in one school near Meridian, there were 59 pregnancies in the school. The following year—well, 2 years later after we had an opportunity to implement the program, there were 11.

Now, we are setting up some rather sophisticated evaluation techniques that I hope will meet the test of the national people who criticize these sorts of things. But we believe that the use of nurses in this kind of role in schools in Mississippi will be effective.

We feel strongly that providing these services to teens and to other persons at risk—obviously, the family planning services work, and if they can help these individuals space their pregnancies better and have a smaller number, they are more likely to have safer outcomes. They are better able to have opportunities for educational advancement and generally improve their lot in life.

So, in summary, we are strongly in support of the legislation. We support the provisions that would make available a reasonable amount of money for research and training, particularly research in new methods. I do not think we have the perfect methods at all.

I think we need a lot of research in community application of this. It is not just the health department's job; there are a lot of other agencies that need to be involved. We need some increased demonstration funds and research funds to continue the training funds that we have had like at our regional center in Atlanta at Emory University.

[The prepared statement of Dr. Cobb follows:]

TESTIMONY BEFORE THE UNITED STATES

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

Madam Chair and distinguished members of the committee, I am Dr. Alton B. Cobb, director of the Mississippi State Department of Health. I am delighted to have the opportunity to testify regarding re-authorization of Title X of the Public Health Service Act and to describe what these services mean to Mississippi in our efforts to lower infant mortality, decrease dependency, and expand social and economic opportunities for our people.

In Mississippi, the Department of Health provides our patients comprehensive family planning services, which include confidential counseling, examinations (including cancer screening), education, and contraceptives. Additional special areas addressed by the program include the provision of surgical sterilization to both men and women and infertility services for persons who desire pregnancy.

In 1986, the state Family Planning program served 97,314 unduplicated patients including 27,910 teenagers at approximately 150 clinic sites throughout the state. Using nationally accepted evaluation indicators, the family planning program prevented 15,862 unwanted pregnancies in 1986; of those, some 4,400 would have been pregnancies to teenagers. Of the individuals served, 93% met the criteria of target population users, which is defined as adult women with incomes at or below 150% of poverty and sexually active teens. While Mississippi is at or near the top among the states in relation to the percent of its target population served, services are not available to a significant

number of targeted individuals due to inadequate program financing. For fiscal year 1986, Title X directly supported 34% or $3.1 million of the Department of Health's family planning budget ($9.1 million) with the remainder being derived from Medicaid, patient fees, Social Services Block Grant, Maternal and Child Health Block Grant, and state funds. Title X funding is essential and represents the primary source of family planning dollars in Mississippi. Because Mississippi's average medical cost per user is well below that of the nation, it is clear that available funds are being spent efficiently; we need increased program funding.

In Mississippi, family planning is an essential component of an integrated system of care for mothers, infants, and children which includes delivery of statewide prenatal, WIC, and child health services. Significant strides have been made during the last quarter century in reducing the state's infant mortality rate from 41 deaths per thousand live births in 1960 to 12.3 in 1986. Race specific rates for 1986 were 8.9 for whites and 16.2 for blacks. Family planning services, especially those targeted to teens, have contributed to this reduction by preventing unintended pregnancies among women at risk of poor pregnancy outcomes. Clearly, any attempts to further reduce infant mortality in Mississippi must continue efforts toward substantial reduction of the teenage pregnancy rate and further reductions in fertility rates in our low income/high risk population groups.

I would like to direct your attention briefly to the issue of teens and family planning services. Over the last decade, Mississippi has consistently had one of the highest teenage fertility rates in the country. Because of these high

fertility rates, the state has one of the highest proportions of births to teenage mothers -- children having children. Teenage pregnancy causes substantial medical, social, and economic problems. Focusing solely on the economic influence of teen pregnancies, Mississippi mothers who had their first child as teenagers account for 31% of the AFDC (Welfare) budget. These mothers also account for a major part of many other assistance programs including food stamps, Medicaid, and housing.

Even though Mississippi has a serious problem with teenage pregnancy, teen births as a percent of total births have been gradually declining since 1974. This decline parallels the availability of free and confidential services for all teens. Although emphasis on family involvement is a strong component of our program, state law permits service to sexually active teens without parental consent or notification. We have consistently opposed any proposed law or regulation requiring parental notification because we are convinced that teen pregnancies and infant deaths would increase since some teens, fearing parental reprisal, would drop out of family planning clinics. Our view is that when strong and positive family relationships exist family involvement is present.

We encourage every teen to counsel with a parent or an adult family member regarding sexuality and contraception. Unhappily, the evidence clearly suggests that many parents are unable to adequately communicate on the sensitive subjects of contraception and sexuality. Many teens served at the health department do not have parents with whom they can discuss such issues.

A recent Harris poll indicates that teens have been sexually active at least three months before coming to family planning clinics. In our counseling with teens, we always urge abstinence as the best method of contraception, but we realize that many teens are having sex. Research has shown that once teens have become sexually active, few will abstain.

Accurate information is the key to prevention. One strategy we use is the placement of public health nurses in junior high schools. Successful pilot projects in two public health districts have involved the education system, the health system, and the community to address issues such as general health, alcohol, drug and tobacco abuse, nutrition, counseling on sexuality, and AIDS.

We would like to expand the school nurse program and continue all other health education efforts so that this target teenage public can receive not only sound information about prevention of pregnancies and diseases but also have access to additional staff who can help assure that all individuals are fully informed of their health care options.

I am proud of the progress we have made in Mississippi, but even with our targeted efforts, we are not able to make voluntary family planning services available to all Mississippians desiring such services. We don't have enough money.

In short, I applaud the use of the Title X funds nationwide and recognize the national impact of these dollars in assuring that women and teens have

access to quality family planning services. In Mississippi, Title X funds are an integral part of our efforts to meet the 1990 objectives for the Nation regarding perinatal and maternal health.

I wish to thank you for your support of Title X in the past and ask that the funding provisions set forth in S. 1366 be enacted. It is clear that adequate increases are needed to meet rising program costs and to increase the percent of target population served. Reasonable allocation for research, training, technical assistance and data collection should also be made.

Senator MIKULSKI. Thank you, Doctor. That testimony was excellent.

Dr. COBB. Thank you.

Senator MIKULSKI. I gather you have been a pretty good teacher yourself.

Let us move on now to Mr. Scott R. Swirling, who is going to testify on behalf of the National Family Planning and Reproductive Health Association. Mr. Swirling, I see that you have a testimony that even though the pages are not marked is quite lengthy.

So, without objection, your statement will be entered into the record.

If you could summarize, it would be appreciated.

Mr. SWIRLING. Thank you. Madam Chairwoman and members of the committee, as the executive director of the National Family Planning and Reproductive Health Association, I am pleased to testify today, first, to support the reauthorization of the title X family planning statute and, second, to set the record straight regarding the statements and allegations made about the National Family Planning Program by individuals opposed to the program and to the Federal effort to provide high-quality, comprehensive family planning services to low-income women and families.

NFPRHA is the only national organization that represents the entire diverse community of providers and consumers of title X services, from State and local health departments to hospitals, from Planned Parenthood affiliates to independent, free-standing family planning clinics and individual health care professionals.

Title X is primarily a public health services program that serves the poor and medically indigent. We are outraged that President Reagan would undertake actions that will deprive poor women of the same comprehensive, high-quality health care available to wealthier women.

These simplistic policy changes are ill-conceived, misguided, untenable, illegal, and unconstitutional. Title X provides the infrastructure for the organized delivery of publicly-funded——

Senator MIKULSKI. Mr. Swirling, I would like to caution you in the same way I cautioned Dr. Cobb. It is hard to hear. Speak into the microphone, and even though I want you to summarize, take it easy. I want to hear what you have to say.

Mr. SWIRLING. I am looking at my five-minute limit, Madam Chairman.

Senator MIKULSKI. Yes, but we would like to hear what you say in your five minutes.

Mr. SWIRLING. OK.

The pregnancies avoided by the utilization of title X services limit the number of abortions and unintended births that occur each year in the United States. Congressional passage of S. 1366 will go a long way to ensuring that low-income women and sexually active teenagers will not have to go without the family planning services they so desperately desire and need to prevent unintended pregnancies and the severe consequences associated with such pregnancies.

Unfortunately, opponents of title X have foisted the canard that title X funds subsidize abortion. Under the guise of opposing abortion, these individuals are trying to undermine the single most ef-

fective Federal effort for reducing the need for abortion, the National Title X Family Planning Program.

Throughout title X's 17-year history, family planning providers have been scrupulous in their adherence to the letter and intent of the law and all appropriate regulations. Despite this demonstrable fact, family planning opponents assert that title X funds are provided improperly to certain family planning agencies or are being misused by those agencies.

They claim the title X statute does not allow funds to go to agencies that provide abortions with non-Federal funds. They claim there is a "taint of abortion and abortion-related activities" that must be removed from the program.

These allegations are baseless and wholly without substance. At best, they are inaccurate and misleading. At worst, they are simply untrue. When title X was enacted in 1970, abortion was proscribed in many States, but legal in others.

Congress included in title X a prohibition on the use of title X funds for abortion. The December 3, 1970 conference report to accompany the title X bill stated Congress' intent. The legislation does not and is not intended to interfere with or limit programs conducted in accordance with State or local laws and regulations which are supported by funds other than those under this legislation.

Simply stated, Congress specifically provided that agencies in States where abortion was legal in 1970 could operate under those State laws regarding abortion and still receive title X funds for family planning services programs. Those agencies, however, cannot utilize title X funds for abortion.

Thus, under original Congressional intent and edict, agencies involved in abortion with non-title X funds can and do receive title X funds for their family planning programs. They operate their title X family planning programs appropriately and legally segregated from any prohibited activities, in full compliance with section 1008.

Further buttressing the validity of the original congressional intent, in November 1986 the U.S. Supreme Court struck down an Arizona law that attempted to prohibit the provision of State funds to agencies involved in abortion with non-State funds, a situation directly analogous to the argument presented by title X's opponents.

The court held it unconstitutional for States to deny family planning funds to private organizations because they legally provide abortions or other related counseling and referral services with non-State funds.

Opponents of the title X program claim that title X funds are inappropriately subsidizing abortions through the numerous agencies at which abortions are provided in the same facilities as family planning services. DHHS's own figures show that only 85 clinics out of 4,000 nationwide are abortions also performed, and those abortions are performed without title X funds.

Since the inception of the program, DHHS's title X regulations have required physicians and other clinicians to provide for medical services related to family planning and appropriate social service counseling and referral. Thus, pregnancy-related counseling and referral services are an appropriate part of the program.

Neither HHS Office of Inspector General nor the General Accounting Office have ever been able to substantiate the allegations that have been made. In its last report on the subject in 1982, GAO stated that "It found no evidence that title X funds had been used for abortions or to advise clients to have abortions."

In the Office of Inspector General audits in 1981 and 1982, the Office of Inspector General stated in numerous places, "We determined that the agency did not use title X funds for abortion-related activities," or "our tests of expenditures did not disclose any problems in terms of accountability for such funds." "We found no expenditures that were in violation of the Act or other regulatory requirements, and we found no evidence that the agency was providing abortion-related services to family planning clients or using title X funds for direct abortion services."

As Senator Kennedy noted, both Secretary Heckler and Secretary Bowen have stated that title X clinics are in full compliance with the law.

In conclusion, there is not a scintilla of evidence that title X family planning agencies are in violation in any way with section 1008. Allegations to the contrary must be seen for what they are, efforts to harass, discredit, and undermine the family planning program under title X.

NFPRHA asks this committee and the Congress to focus not on unfounded allegations, but on the well documented public health needs and successes of the national title X family planning program. NFPRHA urges swift enactment of S. 1366 and the reauthorization of the title X statute.

Thank you.

[The prepared statement of Mr. Swirling follows:]

NFPRHA National Family Planning and Reproductive Health Association, Inc.

TESTIMONY

OF

SCOTT R. SWIRLING

ON BEHALF OF THE

NATIONAL FAMILY PLANNING

AND

REPRODUCTIVE HEALTH ASSOCIATION

BEFORE THE

COMMITTEE ON LABOR & HUMAN RESOURCES

UNITED STATES SENATE

ON S. 1366, A BILL TO REAUTHORIZE

THE NATIONAL FAMILY PLANNING PROGRAM

-- TITLE X OF THE PUBLIC HEALTH SERVICE ACT --

JULY 30, 1987

122 C Street, N.W., Suite 380, Washington, D.C. 20001-2109 (202) 628-3535

Mr. Chairman and Members of the Committee:

I am Scott R. Swirling, Executive Director of the National Family Planning and Reproductive Health Association, Inc. (NFPRHA). On behalf of NFPRHA, I thank you for this opportunity to testify in support of the reauthorization of the national family planning program -- Title X of the Public Health Service Act. In particular, NFPRHA endorses the passage of S. 1366, the reauthorization legislation introduced by Senator Kennedy and co-sponsored by over two-thirds of the members of this committee.

The National Family Planning and Reproductive Health Association (NFPRHA) is a non-profit membership organization headquartered in Washington, D.C., established to improve and expand the delivery of voluntary family planning and reproductive health care services throughout the United States. As the only national organization representing the entire family planning community, from consumers to state, county and local health departments; from hospital-based clinics to affiliates of the Planned Parenthood Federation of America; from umbrella funding councils to independent, free-standing family planning clinics and individual health care professionals, NFPRHA is committed to establishing and maintaining reproductive health care as a high priority preventive health care service in this country.

TITLE X -- A NECESSARY PUBLIC HEALTH PROGRAM

In a message to the Congress in July 1970, President Richard M. Nixon stated,

> It is my view that no American woman should be denied access to family planning assistance because of her economic condition. I believe, therefore, that we should establish as a national

> goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them. This we have the capacity to do.

The Family Planning Services and Population Research Act (P.L. 91-572) subsequently was signed into law by in December, 1970. During the seventeen years since then, the national family planning program has been an integral component of the panoply of programs designed to improve public health in the United States.

Title X is primarily a health services program that serves the poor and medically indigent. Through a network of over 4,000 clinics, family planning agencies serve as the entry point for millions of low-income women and adolescents into the nation's health care system. For many, it is the only source of health care readily available.

This network is incredibly diverse, with providers of varied types offering family planning services with Title X funds. State and local health departments constitute the single largest group of providers, serving 40 percent of the Title X clients. Affiliates of the Planned Parenthood Federation of America serve 27 percent of the clients; hospitals, 13 percent; and a variety of other agencies such as health maintenance organizations, community health centers, and independent clinics serve the remaining 20 percent.

This network, established and operated under the Title X program, provides the infrastructure for the organized delivery of publicly-funded family planning services. While Title X is the single largest source of public support for family planning -- providing over one-third of the total public family planning funds -- it is augmented by: .the Maternal and Child Health Block Grant

(Title V of the Social Security Act); Medicaid (Title XIX of the Social Security Act); the Social Services Block Grant (Title XX of the Social Security Act); state and local funding; patient fees; other third party reimbursements; and private philanthropy.

The average Title X client is young, female, and has a low or marginal income. Sixty-nine percent of the clients are white, and eighty percent have incomes below 150 percent of the federal poverty level.

Typical Title X programs offer clinical health services (physical examinations; contraceptive information and services, including natural family planning; Pap smears; sexually transmitted disease screening and treatment; cancer screening; hemoglobin tests; urinalysis; pregnancy testing and diagnosis; and basic gynecologic care); counseling services (for nutrition, infertility, parent/teen communication, maternal and child health, and related medical problems); services for men (counseling, education, condoms); special teen clinics; adolescent health education; and community education programs.

The need for the Title X program is clear and considerable. Although 3.5 million low-income women and 1.5 million adolescents receive services yearly from Title X clinics, 56 percent of the over 9.5 millon low-income women and 69 percent of the five million sexually-active teenagers in need of subsidized family planning services still cannot obtain medically supervised reproductive health care.

Hundreds of thousands of unintended pregnancies, many among teenagers, are averted each year as a direct result of services provided by clinics receiving Title X funds.

Even with Title X, over fifty percent of the six million pregnancies yearly in this country are unintended; 1.1 million of those pregnancies are to teenagers. Eighty percent of all teenage pregnancies are unintended. Over 1.5 million abortions occur each year, more than 400,000 to teenagers.

Pregnancies avoided by the utilization of Title X family planning services limit the numbers of abortions and unintended births that occur each year in the United States.

Department of Health and Human Services Secretary Otis R. Bowen has noted, "Between their 13th and 19th birthdays, more than one quarter of all teenage girls will be pregnant at least once. Pregnancy among unmarried teens is a problem for both the girls having babies and the boys who father them. And it is a problem we all must face...not just the government, but all of us."

That problem is not simply whether a pregnant teenager chooses to give birth or to have an abortion. As the Center for Population Options documented in its 1986 study on the public costs of teenage childbearing,

> The more than one million teenage pregnancies that occur each year are a serious problem for all of society. Not only is teenage childbearing a threat to the health and welfare of the mother and child, but adolescent pregnancy contributes to such societal problems as poverty, unemployment, family disintegration, juvenile crime, school dropouts and child abuse.

Thus, the federal dollars invested in Title X to prevent pregnancy more than pay for themselves in savings in public health care and social service costs.

Unfortunately, despite the Presidential call for total access to family planning services by 1975, federal, state, and local

financial support for family planning has never reached a level commensurate with need. Since the early 1970's, the number of medically indigent family planning clients has grown more than 60 percent, yet federal funding for family planning has not increased in real dollars since 1973.

Congressional passage of S. 1366 will go a long way to ensuring that low-income women and sexually active teenagers will not have to go without the family planning services they so desperately desire and need to prevent unintended pregnancies and the severe consequences associated with such pregnancies.

S. 1366 -- A STEP FORWARD

The authorization of the Title X statute expired on September 30, 1985. For the last two fiscal years, the Title X appropriation has been carried on a series of Continuing Resolutions. The result has been a near freeze on the funding of the family planning program since October 1985.

In fiscal year 1981, the appropriation for all programs under the Title X statute was $162 million. That figure dropped to $124.8 million in fiscal year 1982, $124 million in fiscal year 1983, $140 million in fiscal year 1984, and $142.5 million in fiscal year 1985. In fiscal year 1986, additional Gramm-Rudman-Hollings cuts brought the actual Title X appropriation back down to $136.4 million. For fiscal year 1987, without Gramm-Rudman-Hollings reductions, the Title X appropriation is once again 142.5 million.

According to DHHS figures, the funding reductions in the early 1980's forced the closing of almost 1,000 clinics and the curtailment of many services. Operating hours have been reduced, staff

have been cut, and indigent patients have been asked to contribute more to the cost of services. The irony of this is, of course, that reducing a program as effective and cost-efficient as Title X results only in far greater social and financial costs down the line.

By providing modest increases in the authorized funding levels for basic family planning services, and for training programs and technical assistance programs, enactment of S. 1366 will permit the restoration of some services and the provision of preventive reproductive health services to additional clients.

The minor programmatic changes proposed in S. 1366 will ensure the collection and analysis of appropriate data; more clearly define the type of research projects that should be funded to investigate methods to improve service delivery; assure the continued clinical training of family planning nurse practitioners; and remove from the statute an unnecesaary funding provision that has never been utilized.

The two major new initiatives proposed in S. 1366 address vital needs for the American public. The limitations in number, quality and efficacy of current contraceptive methods require the intensive effort to develop, market and evaluate new contraceptive devices, drugs and methods proposed by Section 7 of S. 1366.

And, with the understanding that "knowledge is power," S. 1366 would increase the knowledge of individuals -- particularly teenagers and their parents --about methods to prevent unintended pregnancy and the contraction of sexually transmitted diseases through the enhancement of the public, community-based information

and education programs funded under Title X.

The National Family Planning and Reproductive Health Association wholeheartedly endorses the passage of S. 1366 and the reauthorization of the Title X family planning statute for four years, through fiscal year 1991.

TITLE X -- SURVIVING SEVEN YEARS OF HARASSMENT

Despite Title X's record of accomplishment, the Reagan administration has consistently sought to repeal the Title X program for ideological and political reasons, and failing that, to significantly reduce the program's funding and undertake administrative harassment designed to destroy the integrity and efficacy of the national family planning program.

However, Congressional and public recognition of Title X's important public health role has enabled the program to withstand seven years of assault by the Reagan administration and its anti-family planning allies.

The litany of actions inimicable to the Title X statute and the best interests of high quality family planning service delivery is seemingly endless. Among the highlights of the last seven years are:

1. The consecutive appointment as Deputy Assistant Secretary for Population Affairs charged with administering the national family planning program of three individuals who are personnally opposed to the program.
2. The refusal since 1982 to appoint a qualified public health professional and administrator as Director of the Office of Family Planning within OPA.
3. The proposing -- seven times -- of the repeal of the Title

X family planning statute and its replacement with a block grant designed to undermine the delivery of comprehensive, high quality family planning services throughout every state and region.

4. The proposing of major budget cuts and the impoundment of appropriated Title X funds in fiscal year 1982 which were released only upon the filing of a lawsuit by NFPRHA and others.
5. The institution of an unprecedented number of audits of family planning providers by the DHHS Office of Inspector General.
6. The transfer of the Office of Family Planning from the complex of professionally-administered public health programs in the Bureau of Health Care Delivery and Assistance and to a place in isolation in the Office of the Assistant Secretary for Health.
7. The "de-funding" of grantees under the Title X service delivery improvement program because of their opposition to the Reagan administration's anti-family planning efforts.
8. The promulgation of the "squeal rule" -- a regulation to require parental notification for the provision of prescription contraceptives to minors -- that was struck down by federal courts as antithetical to the Title X statute in a lawsuit brought by NFPRHA and others.
9. The proposal by the Office of Management and Budget -- withdrawn after a two year outcry -- to prohibit "public

advocacy" with non-federal funds by Title X and other federal grantees.

Most recently, through a series of pointed administrative efforts to substitute political ideology for statutory requirements, the resources of the Department of Health and Human Services have been misapplied to undermine the delivery of family planning services through Title X.

For more than a year, and most specifically from January 21 of this year through July 2, the personal anti-abortion philosophy of the former DASPA and her senior advisors distorted the administration of the Title X program -- a program designed to prevent abortion through preventive family planning services. The DASPA attempted to implement the Title X program in a way that was in contradiction to seventeen years of DHHS policy, in contradiction to DHHS General Counsel advice, and most importantly, even in contradiction to Title X's statutory history and Congressional intent.

Although a new DASPA has been appointed, DHHS has not disavowed the actions of the former DASPA nor indicated that the family planning program will now be administered in a professional and competent manner. Further, NFPRHA is disappointed by the appointment as DASPA of another individual who is opposed to the Title X program. In previous positions, the new DASPA has supported and undertaken efforts to undermine the Title X statute and program. NFPRHA hopes that the new DASPA will be instructed by Secretary Bowen to correct the management problems of the past seven years, to administer the program properly, and not to interpose her personal beliefs in lieu of the law.

The major controversies contrived by officials of DHHS over the years severely diminishes the Public Health Service's credibility and its ability to perform required monitoring and support of family planning programs. These actions distract those Title X-funded agencies from the appropriate provision of high quality services to their clients. The controversies disrupt planning and budgeting by family planning agencies and hinder the day-to-day operations of the clinics by the distractions and uncertainties they create.

The emphasis on assuring abortion separation from family planning in Title X -- in spite of the fact that no evidence exists demonstrating non-compliance with the aborton prohibition contained in Section 1008 of the Title X statute -- can only be seen as the implementation of personal philosophy by federal officials sworn to uphold and administer the law. It has prevented any effort to address the appropriate administrative and managerial concerns facing Title X projects today. The following is only a short list of the many items of crucial importance that have been ignored, have remained unresolved, or or have been improperly handled by the DHHS Office of Population Affairs:

1. The formula for allocating Title X service dollars is woefully out-of-date, yet the only effort to revise it resulted in a program motivated by a philosophy designed to skew funding from cost-efficient preventive family planning services requested by clients to more costly, seldom requested services. So poorly-prepared was the formula that members of the Congressional appropriations

committees stepped in to block its implementation during fiscal year 1987 with report language in the Continuing Resolution.

2. The spread and treatment of sexually transmitted diseases such as chlamydia and penicillin resistant gonorrhea requires uniform advice from OPA, yet OPA has not provided any direction to the projects it administers.
3. Despite the Department's and the nation's focus on AIDS, and the clear necessity for family planning agencies to address this public health threat, OPA has yet to issue any information or guidance on AIDS for Title X projects.
4. The publication of notices of requests for Title X grant applications, and the awarding of grants and contracts, has occurred consistently late, creating major dislocations for the providers of family planning services and training programs.
5. Requests for grant proposals have included, or attempts have been made to include, new and unique requirements designed to limit or deny grant awards to current training and service grantees of whom OPA, apparently personnally, disapproves, despite those grantees more-than-competently meeting the terms and conditions of their current grants.
6. While refusing to address current management priorities despite repeated requests from grantees for advice and assistance in those areas, OPA has repeatedly undertaken studies and issued directives with no apparent relationship to the direct competent provision of high quality

family planning health care.

7. Although limited effort is made to administer the Title X program in compliance with good management practices, OPA misspent considerable time and resources in a short-lived attempt to change the Title X guidelines regarding the provision of non-directional counseling and referral on options for the management of an unintended pregnancy in direct contravention to statutory and constitutional requirements.

Title X funds have never subsidized abortion procedures. Yet, under the guise of opposing abortion, some individuals in DHHS and and Congress, and some organizations opposed to family planning, have made unsubstantiated and incorrect allegations about the program so as to undermine the single most effective federal effort for reducing the need for abortion -- the national Title X family planning program.

THE FACTS SHOW STRICT COMPLIANCE WITH THE LETTER AND INTENT OF SECTION 1008 BY TITLE X PROVIDERS

Throughout the seventeen year history of the Title X program, family planning providers have been scrupulous in their adherence to the letter and intent of the law and all appropriate regulations. Despite this demonstrable fact, family planning opponents continue to assert that Title X funds are being provided improperly to certain family planning agencies or being misused by family planning agencies.

In particular, the charge is made that there is a "taint of abortion and abortion-related activities" that must be removed from the Title X family planning program. Those who make this charge

claim that agencies that provide abortions or abortion-related services -- with non-federal funds -- are prohibited by the Title X statute and Congressional intent from receiving Title X funds; for seventeen years, they declare, DHHS has been funding such agencies illegally.

Further, these family planning opponents state, there is a "perceived entanglement" of abortion with the Title X family planning program and that family planning providers illegally misuse their federal dollars to provide abortions or to engage in prohibited abortion-related activities.

These allegations are baseless and wholly without substance. At best they are inaccurate and misleading. At worst, they are simply untrue.

Congress enacted P.L. 91-667 in 1970, prior to the United States Supreme Court's Roe v. Wade decision legalizing abortion throughout the country. In 1970, abortion was proscribed in many states, but legal in others. That year, Congress included in the original family planning statute a provision that remains unchanged today: "Section 1008 -- None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."

The December 3, 1970 conference report to accompany the Title X bill [House Report 91-1667 to accompany S. 2108] stated Congress' intent:

> It is and has been the intent of both House that the funds authorized under this legislation be used only to support preventive family planning services, population research, infertility services and other related medical, information, and educational activities. The Conferees have adopt-

> ed the language in Section 1008, which prohibits the use of such funds for abortion, in order to make clear this intent. The legislation does not and is not intended to interfere with or limit programs conducted in accordance with state or local laws and regulations which are supported by funds other than those under this legislation.

Simply stated, Congress specifically provided that agencies in states where abortion was legal in 1970 could operate under those state laws regarding abortion and still receive Title X funds for family planning services programs. Those agencies, however, could not utilize Title X funds for abortions. Thus, under original Congressional intent and edict, agencies involved in abortion with non-Title X funds can and do receive Title X funds for their family planning programs. They operate their Title X family programs appropriately and legally segregated from any prohibited activities, in full compliance with Section 1008.

Further buttressing the validity of the original Congressional intent in enacting Section 1008, in November 1986, the U.S. Supreme Court struck down an Arizona law that attempted to prohibit the provision of state funds to agencies involved in abortion with non-state funds, a situation directly analagous to the argument presented by Title X's opponents. By a 5 to 3 vote, in Babbitt v. Planned Parenthood of Central and Northern Arizona, the Court summarily affirmed a U.S. Court of Appeals decision which held it unconstitutional for states to deny family planning funds to private organizations because they legally provide abortions or offer related counseling and referral services with non-state funds.

Opponents of the Title X program claim that Title X funds are inappropriately subsidizing abortions through the "numerous"

agencies at which abortions are provided in the same facilities as are family planning services. Further, they claim that providing information to pregnant women about the availability of abortion through nondirective counseling and referral by Title X programs is illegal "advocacy of abortion." Finally, they charge that agencies which are supportive of abortion as a legal option and who advocate for that position with non-federal funds cannot receive Title X funds without their advocacy position interfering with their ability to comply with Section 1008 and to provide quality family planning services as mandated by Title X.

DHHS's own materials document the absurdity of these canards.

According to the latest DHHS figures, out of 4,000 Title X family planning clinics, at only 74 clinics are abortions also performed -- without Title X funds. It is especially noteworthy that, of those 74, 63 percent (or 46 clinics) are located in hospitals. The remainder are Planned Parenthood affiliates (21), other nonprofit organizations (4), and public health departments (3).

Since the inception of the program, DHHS' Title X regulations have required physicians and other clinicians to "provide for medical services related to family planning...and necessary referral to other medical facilities when medically indicated" and to "provide for social services related to family planning, including counseling, referral to and from other social and medical service agencies ...." Thus, pregnancy-related counseling and referral services are an appropriate part of the program.

In accord with the regulations, with the accepted medical

standards promulgated by the American Medical Association and the American College of Obstetricians and Gynecologists, and with the United States Constitution, the Title X guidelines specifically require that women facing an unintended pregnancy are to be provided with non-directive information and counseling, and referral upon request, for all their legal options: prenatal care and delivery; infant care, foster care or adoption; and pregnancy termination.

Neither the DHHS Office of Inspector General nor the General Accounting Office have been able to substantiate the allegations that family planning agencies have used Title X funds to subsidize abortions in co-sited clinics or advocate abortion through counseling and referral. Rather, the contrary is true.

In its last (1982) report on this subject, the GAO stated that it "found no evidence that title X funds had been used for abortions or to advise clients to have abortions."

In the rash of audits in 1981 and 1982, the DHHS OIG repeatedly declared the falsity of the allegations. Typical quotes in audit reports stated, "[W]e determined that (agency) did not use Title X funds for abortion-related activities;" "Our tests of expenditures did not disclose any problems in terms of accountability for such funds or provide any indications that Title X funds were used for unallowable purposes;" "We found no expenditures that were in violation of the Act [Title X] or other regulatory requirements;" and "We found no evidence that [agency] was providing abortion-related services to family planning clients or using Title X funds for direct abortion services."

More recently, in testimony before the House Subcommittee on

Health and the Environment in both 1984 and 1985, and again in testimony before the House Appropriations Subcommittee on Labor, HHS and Education in February 1987, former DHHS Secretary Margaret M. Heckler and current Secretary Bowen specifically reaffirmed that Title X clinics are in full compliance with the Section 1008 prohibitions.

In conclusion, there is not a scintilla of evidence that Title X family planning agencies are in violation in any way with Section 1008. Allegations to the contrary must be seen for what they are: efforts to harass, discredit and undermine the family planning program under Title X.

NFPRHA asks this committee and the Congress to focus not on unfounded allegations, but on the well-documented public health need and successes of the national Title X family planning program. NFPRHA urges the swift enactment of S. 1366 and the reauthorization of the Title X statute.

Mr. Chairman and Members of the Committee, thank you very much for your attention to NFPRHA's testimony. I will be pleased to answer any questions you might wish to ask.

Senator MIKULSKI. That was a crisp summary, Mr. Swirling, and thank you. I think you highlighted your prepared remarks very efficiently.

Mr. SWIRLING. Thank you.

Senator MIKULSKI. Now, I would like to turn to Diana Gurieva, the executive director of Planned Parenthood of Maryland, who actually has the responsibility for administering the program. But I understand you are representing the entire Planned Parenthood Federation of America because Faye Waddleton is over testifying on the family planning issues in Foreign Operations.

Ms. GURIEVA. That is right.

Senator MIKULSKI. So you are presenting here not only a Maryland hands-on, practical experience, but will be representing the entire federation?

Ms. GURIEVA. That is correct. As a matter of fact, I would like to ask your permission to enter a written statement on behalf of Faye Waddleton, president of the national federation, and I would like to have this entered as a written part of the record.

Senator MIKULSKI. Yes.

Ms. GURIEVA. Thank you.

Senator MIKULSKI. Without objection, Ms. Waddleton's entire testimony is into the record.

Senator MIKULSKI. Why do you not proceed with your testimony?

Ms. GURIEVA. Very well, thank you. It truly is an honor to be able to testify here today, particularly before you, Senator Mikulski. I personally want to thank you and express my gratitude for your unwavering support for title X when you were in the House and to tell you how much we have already enjoyed and will continue to look forward to working with you on title X in the future.

Planned Parenthood does, in fact, strongly support a 4-year reauthorization of title X, the National Family Planning Program, which since 1970 has been the backbone of the national family planning clinic network which Planned Parenthood of Maryland is a part of.

As the last witness today, I am going to try to be very brief, but I want to try to highlight for you what title X represents for me as a service provider. Title X is perhaps best known as a family planning program. As a matter of fact, family planning are the words that are part of the title of the act.

Dr. Cobb did a very excellent job earlier of talking about the breadth of services that is provided under title X over and above family planning services, and I think that is a very important point for us not to forget that title X is a preventive health program that provides preventive health screening to women who very, very often have no other source of care.

We did a survey of Planned Parenthood of Maryland clinics earlier this year and one of the questions we asked the women was whether they had other sources of ongoing or periodic medical care. Well over 50 percent of all of our contraceptive patients in our title X clinics indicated that they had no other source of medical care for the entire preceding year; that they were coming to family planning clinics for their primary source of care. That was data from patients that we surveyed a couple of months ago.

Earlier today, title X was depicted as an abortion program. As a matter of fact, if I had not known better, I would have thought I was sitting in a hearing on abortion legislation, not on family planning legislation.

On the contrary, I would like to submit that title X is probably the only major Federal health program that, by design, aims to actually reduce the need for abortion by preventing unintended pregnancy.

There is something quite ironic in the twisted logic of those anti-abortion groups that have repeatedly attempted to dismantle the title X program, as evidenced today by President Reagan's plans. To me, it feels like a replay of the administration's earlier misguided efforts to circumvent the will of Congress and promulgate what was then called the squeal rule, the parental notification requirements.

I have to say that opposition to abortion does not have to equate, does not have to be synonymous with opposition to family planning. I am proud to say that in Maryland—and I think you know about this, Senator Mikulski—we have had a remarkable experience of support for family planning from both sides of the political fence.

Last year, through the efforts of my organization and through other community groups concerned with unintended pregnancy and teen pregnancy, a remarkable bipartisan coalition of Maryland legislators from both sides of the pro-choice and anti-abortion arenas got together and made a decision to put aside their differences on abortion to agree to disagree on the issue of abortion in order to do something positive about the issue of inintended pregnancy.

They called upon the governor of the State to enhance the delivery of family planning services to sexually active teens and stressed the importance of guaranteeing confidentiality. In all, we had 122 members of the Maryland General Assembly out of 188 support this effort.

As a result of that effort, then Governor Hughes included in the fiscal year 1987 budget a $2.3 million initiative for teen pregnancy in Maryland that included an additional $400,000 for family planning programs.

Title X represents for me, again, as a service provider, the single best line of attack against teen pregnancy. As you know, Baltimore City rates amongst the highest in the country for teen births. The State of Maryland ranks fourth in the number of births to teenagers.

A recent Harris poll commissioned by Planned Parenthood found that 84 percent of Americans said that they believed that teen pregnancy was indeed a serious problem. Further, a majority of adults agreed that making contraceptives more difficult for teenagers to obtain, such as parental notification would, would cause more teen pregnancy. These were the opinions of American adults surveyed through the Lou Harris organization.

Recently, the National Academy of Science concluded that diligent use of contraception by sexually active teens is the best strategy for the prevention of teen pregnancy, and one of NAS' specific recommendations was the reauthorization of the title X program.

We support the reauthorization of the program. We support, also, the two new initiatives included in S. 1366. Before I conclude, I want to make one further statement about an issue that has not been brought up today, but is an issue that is going to be increasingly important to those of us who are on the front line of providing services to women in need, and that is the issue of AIDS.

Earlier, we talked about the breadth of services provided through family planning programs; in particular, STD's, screening for sexually-transmitted diseases. Maryland and Washington, DC, as a matter of fact, rank highest in the nation in the incidence of sexually-transmitted diseases, and now we are faced with the new and deadly disease of AIDS.

Women are at risk of AIDS, and many of the women that we are seeing in our clinics are at risk of AIDS. The new challenges of AIDS compound the need for expanded information, education, counseling, and screening programs within our clinics and we simply cannot do that without additional resources.

I might add that we support strongly the legislation introduced by Congressman Waxman this morning having to do with funding for AIDS.

I would just like to conclude by saying that it is time to——

Senator MIKULSKI. You really have to, yes.

Ms. GURIEVA. Pardon me?

Senator MIKULSKI. You really have to conclude.

Ms. GURIEVA. The last point I want to make is that I think we need to remember that family planning is a basic public health service and not another political battle ground on which to debate the issue of abortion.

Instead, I think we can look at title X as an opportunity for legislators on both sides of the abortion issue to do something positive to limit the incidence of abortion.

I thank you very much, Madam Chair.

[The prepared statement of Ms. Gurieva follows:]

Diana Gurieva, Executive Director
Planned Parenthood of Maryland
Senate Labor and Human Resources Committee
July 30, 1987

Senator Mikulski, Members of the Committee, I am Diana Gurieva, Executive Director for Planned Parenthood of Maryland, today representing Planned Parenthood Federation of America.

It is an honor to testify before this Committee in support of S. 1366, and particularly before you, Senator Mikulski. We are grateful for your unwaivering support of the Title X program in the House and we look forward to working with you now in the Senate.

Planned Parenthood supports S. 1366, a four-year reauthorization of the Title X family planning program. Since 1970, Title X has served as the backbone of our national family planning clinic network that provides medical and education services to over five million low-income women and teenagers in 4500 local clinics around the country. While the primary focus of Title X is contraception, Title X-supported clinics offer a range of basic preventive health services, and are often the first place low-income women -- and especially teenagers -- receive formal medical care.

Moreover, the Title X family planning program is the only major federal health program that by design aims to reduce the need for abortion. More than half of the approximately six million pregnancies that occur each year are unintended, and half of those unintended pregnancies end in abortion. It is a terrible irony that the interest groups that most strongly oppose abortion, are the very ones who have tried repeatedly to dismantle the national family planning program.

There has been a lot of discussion recently about the problem of adolescent pregnancy, and I would like to spend a minute talking about the importance of adolescent services under Title X. A recent Harris poll commissioned by Planned Parenthood found that 84% of Americans believe teen pregnancy is a serious problem. While the solutions to this problem are complex, a panel of experts convened by the National Academy of Sciences recently concluded that diligent use of contraception by sexually active teens is the surest strategy for prevention of teen pregnancies. One of the Academy's specific recommendations is the reauthorization of the Title X program.

As you know, Senator Mikulski, Baltimore city has one of the highest teenage pregnancy rates in the nation, while Maryland ranks fourth in the number of births to teens. Two years ago, through the efforts of Planned Parenthood of Maryland and a number of other community groups concerned about the teen pregnancy problem, a remarkable coalition of Maryland legislators decided to put aside their differences on the issue of abortion, and do something positive to address the problem of teen pregnancy. They called upon the Governor to enhance the delivery of family planning services to sexually active teenagers and stressed the importance of guaranteeing confidentiality. In all 122 of the 188 members of the General Assembly, an unprecedented majority of state legislators on opposite sides of the abortion issue, signed a letter to the Governor. As a result, Governor Hughes included in the FY87 budget $2.3 million for a teen pregnancy initiative, which included an additional $400,000 for family planning programs.

Planned Parenthood supports the reauthorization of the Title X program and the two new initiatives included in S. 1366. We need to

expand our efforts to find more safe and effective methods of contraception to further reduce the need for abortion. And we need to do more -- not less -- to reach out to adolescents with information and education to help them make responsible decisions about their sexuality and their futures.

But most importantly, we need to ensure adequate funding levels for the Title program if we are to meet the demands facing the program today and the new challenges on the horizon. One such challenge is AIDS. Family planning providers are uniquely positioned to provide the information, education, and in time, voluntary testing and counseling services, that will be needed to stem the spread of AIDS among heterosexual women and their infants. In Maryland, where the problem of AIDS among women and infants -- particularly among minorities -- is already a serious problem, we have begun to meet that challenge. But we cannot do that without additional resources.

In 1981, family planning, along with most other domestic health programs, took a drastic 22 percent cut in appropriations. This year's appropriation of $142.5 million -- which has not increased over the last two years -- is still more than $24 million below FY1981's level, not adjusting for inflation.

It is also time that we again think of family planning as a basic public health service -- a part of our overall effort to improve maternal and child health -- and not as another political battleground on which to debate the issue of abortion. The attacks by the current administration on the Title X program, and on Planned Parenthood in particular, should stop.

We urge prompt passage of S. 1366, and once again, I thank the Chair and the Committee for this opportunity to testify.

Senator MIKULSKI. Thank you. It is just that we wanted to move to the questioning.

Thank you, Senator Humphrey, for joining us. We want to be sure that your rights were protected in the questioning.

Ms. Gurieva, I am glad that you brought up the subject of teenagers, teenage pregnancy, and the issue of AIDS. I want to ask you some questions. As you know, teenagers as a group tend to be risktakers. Do you feel that the information and education section of title X will really do anything to help the prevention of the spread of AIDS among our teenagers?

Ms. GURIEVA. We have a terrible crisis facing us in relationship to AIDS. We are finding, for example, in Baltimore City that Baltimore City young minority men have one of the highest rates of AIDS in the country.

Teenagers, as you said, tend to be risktakers. They tend to experiment, and they also tend to think that they are invulnerable. I think that a lot more than title X is going to be needed to prevent the spread of AIDS to the heterosexual population, but I think that title X providers can play a very, very important role because they have a magnificent opportunity to intervene with large numbers of women who may be at risk for AIDS through an educational intervention that we already provide within our clinics.

Senator MIKULSKI. Are you getting more questions about AIDS now than ever before?

Ms. GURIEVA. We are getting women coming into our clinics who are asking for AIDS testing. We are getting women coming into our clinics telling us that their boyfriends or their partners or their husbands have been tested positive for AIDS.

We are having an average of 30 to 40 telephone calls a day, people asking about AIDS. We have a taped information line where you can call in and we have 55 different messages and people can request a different informational message, and the tape on AIDS is the single most used tape these days.

Our educators who work out in the community doing presentations for parents and churches and groups all over the community—the single most requested topic of information at this time is on AIDS.

Senator MIKULSKI. And you would anticipate that that demand would increase?

Ms. GURIEVA. I think it absolutely would. I think the reason that we are getting those kinds of requests—and I have talked to other providers in other parts of the country and they are feeling very much the same kinds of pressures—is because we are very much a mainstream organization that has a reputation for providing high-quality, sensitive, good information about sexuality to people, and AIDS is clearly seen as part of the larger reproductive health arena and is definitely concerned with sexual issues.

Senator MIKULSKI. Well, I agree and I think that the work that you are doing in AIDS education and information as part of your overall other community outreach is very much within the intent of the Reagan administration, particularly Dr. Koop, who is trying to present a public health perspective on this, and it seems to be doing that.

Ms. GURIEVA. That is right.

Senator MIKULSKI. Mr. Swirling, I would like to move on to you. In your testimony, you spoke of the successes and cost effectiveness of the title X programs. Could you discuss these further and elaborate on who receives Federal funds under title X and what services you provide, because we have heard from Ms. Gurieva and even Dr. Cobb that in some ways you have become a deliverer of primary care, particularly for adults who have no health insurance but are not Medicaid-eligible? Is this a gap for working people not covered by insurance or are these poor people? Are they not covered by Medicaid? What is the deal here?

Mr. SWIRLING. The family planning program under title X is an infrastructure of 4,000 clinics nationwide that provide a broad range of comprehensive health care services in a family planning mode to low-income women and adolescents.

Most particularly, what happens is that women have not had basic medical care before. They come into a family planning clinic and it is their first entry into the system. There are approximately 5 million women served in family planning clinics.

Title X is about one-third of the public funding for family planning services. The rest of the money comes from Medicaid for those women who are Medicaid-eligible. Money comes from the maternal and child health block grant; from the title XX social services block grant, where family planning is the only health care service allowed to be paid for under the social services block grant; State appropriations, as Ms. Gurieva has said, such as in the State of Maryland to augment Federal dollars; as well as from foundation grants, patient fees, other third-party payers, and so forth.

Typical title X programs offer a range of clinical health services, from physical examinations to contraceptive information and services, PAP smears, STD disease treatment and screening, cancer screening, hemoglobin tests, urinalysis, pregnancy testing and diagnosis, basis gynecological care, counseling services, services for men, special services for teens, a broad range of services designed to give family planning patients all the information they need to be able to get into the health care system and take care of their reproductive health care needs.

Senator MIKULSKI. Mr. Swirling, thank you.

Dr. Cobb, I saw you nodding your head.

Dr. COBB. Yes.

Senator MIKULSKI. You are the top doctor in Mississippi. Do you see the line of my questioning?

Dr. COBB. Yes.

Senator MIKULSKI. With AIDS, there seems to be an additional burden on providers of information and care. There seem to be gaps in services. Certainly, you serve low-income people. Could you comment, really, on that question that I asked Mr. Swirling that somehow or another title X is filling the gap of primary care and also meeting other important community needs, like AIDS education?

Dr. COBB. Well, our clinic system, which includes, of course, a family planning service as a component, represents the primary source of care for a large proportion of low-income people in our State, even though they may have Medicaid. We have many physi-

cians who do not care to accept Medicaid. We therefore will serve them.

We believe we have a high-quality program. We work hard on quality. We do integrate education. We will integrate AIDS intervention and education. All of that is part of good, quality care, and obviously we would not just provide people pills. We have got to provide them a good quality of health care to see that it is safe for them to take this medication, that they understand the medication, that we can take the opportunity, as has already been explained, for many screening tests.

We do over 100,000 cervical cancer screens every year in our State. A major portion of those is among our family planning patients, and we find a couple of hundred patients each year who need to have diagnostic, and some of them have to have surgical treatment. It is the only way they would be found, and by their coming to the family planning clinic they are able to receive all of these other services.

If they do get pregnant, then they have prenatal care through our system. They have WIC; they have the whole array of services that we put together.

Senator MIKULSKI. Well, you answered one of the questions I had, which was what other health services you offer.

Senate bill 1366, Dr. Cobb, expands the information and education section of the current law and creates a grant program for community-based information and education programs, which you obviously place a great deal of stock in.

As a provider, could you discuss the value of these information and education services that are provided, and do you think there needs to be additional Federal assistance in this area?

Dr. COBB. Well, I think that is what we have to start with is helping people understand these problems, and that really has to be done at the community level with the patient, with the family, with the community.

I would think a grant program like that would offer many opportunities to have local groups that could organize and promote programs that really would improve upon those elements that are essential in any of these programs.

I do not think it is something just any one agency can do, and I tried to say that earlier. Sometimes I think we kind of get carried away in Mississippi with what the health department does, but the health department cannot solve teen pregnancy and we cannot solve AIDS, but we are the key agency that is looked to to provide the leadership, put together the community groups, do the community organization, and generally try to make sure that it gets done and try to find the resources to get it done, too, which is always a problem in a State like ours.

Senator MIKULSKI. But your point is that the people who turn to your services in Mississippi and benefit from title X are mainstream women who desperately need primary care not covered often by any other way; that this is not just some little revolving door for medical information for the promiscuous.

Dr. COBB. Of course not.

Senator MIKULSKI. But this is the way people often characterize it, that it is federally funded information for promiscuous people out looking to avoid taking responsibility for their behavior.

Now, Mississippi is a pretty culturally moderate to conservative State. Who comes into your Mississippi clinics?

Dr. COBB. Well, we have a pretty good spread of the general population in most of our clinics. I would say that the non-white population in our family planning clinics outweighs its proportion in relationship to the total population, but we have a significant proportion of white patients.

We have a good spread of income. We have a sliding fee scale. As a matter of fact, in family planning and in our maternity clinics we have almost 10 percent of our patients that pay full cost. They come to our system because it is available, it is accessible, and they believe it is high-quality, and we try to keep it that way.

Senator MIKULSKI. I have a few other questions, but, Senator Humphrey, I would like you to be able to have an opportunity and we can come back to me.

Senator HUMPHREY. The Chair will recognize herself. Thank you, Madam Chairman.

Senator MIKULSKI. The Chair has got a pretty good recognition of herself. [Laughter.]

That yellow light was to warn me to start to wrap it up, so when the buzzer goes off, do not pay any attention to it.

Senator HUMPHREY. Thank you, Madam Chairman.

Well, I want to say to these witnesses what I said earlier. Even though I butt heads with many of these organizations over their involvement in abortion, I have no problems with the other aspects of family planning. But inasmuch as I do not regard abortion as a legitimate means of family planning, I have some serious problems with certain organizations that are to one extent or another involved in abortion advocacy or facilitation or whatever you want to call it. With that caveat, do not take personally my line of questioning.

Ms. Gurieva, you are representing both the Maryland affiliate and the national?

Ms. GURIEVA. That is correct, yes.

Senator HUMPHREY. Well, speaking of the national, just for the record, does the national association regard abortion as a means of family planning?

Ms. GURIEVA. No, I do not believe the national association does regard abortion as a means of family planning. I certainly do not and my organization does not.

Senator HUMPHREY. The national organization statement calls upon its affiliates, does it not, to "recognize as one of their primary responsibilities that the development of high-quality abortion services be promoted and encouraged directly through their own medical facilities and/or through other competent medical institutions in the community?" Is that correct?

Ms. GURIEVA. Would you like me to comment on that?

Senator HUMPHREY. I would rather have a yes or no. Is that correct?

Ms. GURIEVA. I do not know what document you are reading from, but the encouragement of the development of abortion serv-

ices within Planned Parenthood affiliates is a position that the national office has taken, the national headquarters has taken.

Senator HUMPHREY. In looking at "Planned Parenthood Federation of America, Inc., Policy Statements." Is this familiar to you?

Ms. GURIEVA. Okay, I am familiar with that.

Senator HUMPHREY. On page two of this document—I would be happy to hand it to you—under the title "Abortion" in the last paragraph: "Planned Parenthood Federation and its affiliates recognize as one of their primary responsibilities that the development of high-quality abortion services be promoted," presumably by Planned Parenthood affiliates, "and encouraged directly through their own medical facilities and/or through other competent medical institutions in the community."

So irrespective of whether the national association regards abortion as a family planning method, you nevertheless do take the position that your affiliates should, as it says here, recognize one of their primary responsibilities is to develop high-quality abortion services, et cetera.

Ms. GURIEVA. Abortion is part of a comprehensive reproductive health care program for women.

Senator HUMPHREY. I understand that, but I wanted to be sure that that is National Planned Parenthood's position.

Now, turning to the Maryland affiliate, is it just one affiliate or is it a——

Ms. GURIEVA. It is a statewide affiliate and we have ten clinics that make up our system.

Senator HUMPHREY. What is your annual budget, let us say, for 1987?

Ms. GURIEVA. It is about $3.4 million.

Senator HUMPHREY. $3.4 million?

Ms. GURIEVA. That is correct.

Senator HUMPHREY. And of that, how much is title X money?

Ms. GURIEVA. About a little over 15 percent, $540,000.

Senator HUMPHREY. And is there any other Federal money involved in your budget?

Ms. GURIEVA. There is through the medical assistance program in Maryland, Title 19. Those would be the only Federal funds that would flow through the State Department of Health and Mental Hygiene.

Senator HUMPHREY. So about 15 percent of your budget this year is title X money.

Ms. GURIEVA. Yes.

Senator HUMPHREY. What would be the effect on your Maryland affiliate and your 10 clinics if you had not been able to qualify for that $540,000?

Ms. GURIEVA. Well, I have a very hard time imagining any situation under which we would not be able to qualify, seeing as how we provide very high quality services to 20,000 women in the State of Maryland, and that would be a significant loss to the State of Maryland to not have Planned Parenthood of Maryland be part of the State family planning program.

What would the impact be? It would not close down the agency. We would not have to close down our clinics. We would have to significantly limit, though, the availability of services to women in

the community. The effect would be on the women, particularly on the contraceptive patients that come to us, and that is about 20,000 women a year that come to us.

Senator HUMPHREY. Fifteen percent—is that typical for each State? By the way, are the States all organized as one?

Ms. GURIEVA. No. There are about 200 Planned Parenthood affiliates. Some States have multiple affiliates, some States have single affiliates. This is not a monolithic structure and every local Planned Parenthood is an independent, locally-controlled, if you will, voluntary organization, not-for-profit organization that is federated with a national organization.

Senator HUMPHREY. Well, nonetheless, would 15 percent be a pretty standard figure nationwide?

Ms. GURIEVA. I really could not speak to that. I do not know. I think it would vary from possibly, you know, perhaps 5 percent to 60 percent, depending upon the individual agency.

Senator HUMPHREY. And your Maryland affiliate counsels and refers for abortion, is that correct?

Ms. GURIEVA. We counsel and refer for abortion. We also provide abortion at two of our sites.

Senator HUMPHREY. Well, how do you square your involvement with the title X mandate?

Ms. GURIEVA. The mandate that prohibits use of title X funds to provide for or advocate for abortion?

Senator HUMPHREY. Right. Thank you.

Senator MIKULSKI. You know it chapter and verse, do you not?

Ms. GURIEVA. Section 1008, right.

Very carefully and very scrupulously is how we provide for managing both a title X-funded family planning program and a separate, privately-funded program that offers abortion to women in our community.

You know, I could spend half an hour talking about the separation of the two programs in relationship to accounting principles and in relationship to the scrupulous attention that both we pay to that particular matter as well as to the State, as well as the audits that we have already undergone as an agency and gotten clean bills of health on all of those.

But I do not think that is what you are asking in terms of the mechanical separation. We regard abortion as part of, as I said earlier, comprehensive reproductive health care for women. We feel that family planning is part of a continuum of services.

We also provide coposcopy services, for example, for women that have had suspect PAP smears and maybe potentially have problems in regard to uterine cancer, cervical cancer. We also do female sterilization; we also do vasectomies. We provide a broad spectrum of services. Abortion is one of those services.

Every one of those services is treated as a separate program within the organization. We also treat our advocacy program—and we do advocate on abortion and I will not play games on the issue of advocacy and what that means. We have a strong advocacy program that works in the Maryland Legislature. But, again, there is strict accountability and total separation of those services.

What I would like to add is we may have differences of ideology in regard to the issue of abortion and abortion vis-a-vis family planning or the connection of abortion and family planning.

The issue that I have to go back to is that abortion is the law of the land and abortion is legally available in the United States today, and since it is a legally available service we feel that it is imperative that not every family planning organization, but that our family planning organization, Planned Parenthood of Maryland, provide that as part of a continuum of care.

I can assure you, and I would like to assure you that just because we provide abortions as part of our program, we do not emphasize abortion in the same way that we do not emphasize sterilization.

A woman comes in and a woman does not want to get pregnant. We do not push pills versus diaphragms versus sterilization, which is a serious and permanent procedure. This is an issue that we are much too sensitive to and, frankly, in some of my testimony I was talking about some of the efforts that we have had in the State of Maryland to attempt to reduce the need for abortion, which is a cause that I am personally greatly committed to.

I personally would much rather see women contracepting than having to use abortion as their method of family planning.

Senator HUMPHREY. Madam Chairman, may I propose this? May I just continue for about 5 more minutes?

Senator MIKULSKI. You know, Senator Humphrey, I was just about to suggest that. I had a second round. What I would like to do is have you essentially take your time for the second round now to continue your line of questioning and then I will conclude with my own.

Senator HUMPHREY. Thank you.

Well, you say you separate these distinctly different services, of which abortion is one, and I will say family planning is the other category. You say you separate these by strict adherence to accounting principles.

Somehow, that is not satisfying, frankly. It is not enough because, as you know, money is fungible. If you get $540,000 in title X money, however scrupulously—and I do not doubt that you are scrupulous in your administration and accounting—however scrupulously you separate these things, that is $540,000 more that you would not otherwise have that you can spend on abortion advocacy, in part, before the Maryland Legislature, that you can spend on operating your abortion clinics, of which you have two. Am I not correct in that? I mean, money, after all, is fungible. It spends just as easily in one category as another.

Ms. GURIEVA. I do not agree because if title X moneys are specifically earmarked and restricted and monitored to be used exclusively for the support of family planning services—and support of family planning services, I might add, for women who are indigent and teenagers—I do not see family planning providers around the country, and I certainly do not see my own agency and I do not see Planned Parenthoods around the country playing those kinds of money games that you are describing.

The fact that we get half a million dollars in title X funds is what allows us to provide subsidized care to women who would have no other place to go, is what allows us to conduct dozens of

parent-child communications programs with parents and their children.

If we did not have that money, that would not enhance our abortion program. I guess I am having perhaps the same kinds of problems in terms of perspective in looking at how that kind of an argument can be made.

Senator HUMPHREY. Well, it is a simple argument. The argument is this in your case: You have $3.4 million to spend on all of your programs. Without title X, you would have $2.86 million. If you did not have the $540,000, you would have to cut back elsewhere.

The point is that by providing you $540,000 for title X services, the taxpayers are enabling you to spend $540,000 elsewhere on abortion, on abortion advocacy, and things of that kind, which the taxpayers are not obligated to do, and indeed which many of them find highly objectionable. Do you see my point?

Ms. GURIEVA. No, and perhaps I am being a little bit——

Senator HUMPHREY. Try.

Ms. GURIEVA. I am trying very hard to see that particular point, but I think that this has been a point that has been argued in a number of different arenas. Earlier, Mr. Swirling talked about the Arizona case that was specifically on this matter, and if I remember that case correctly, the courts ruled that an organization had every right to spend its other or its own moneys, if you will, on issues related to abortion and abortion advocacy.

I do not think the taxpayers are giving Planned Parenthood $540,000 to spend that money on abortion advocacy. The taxpayers are helping Planned Parenthood provide $540,000 worth of family planning services to indigent women.

Senator HUMPHREY. Well, I did not expect you to agree with me, but I asked a rhetorical question to make a point of view for people listening in on television who might not otherwise understand the issue—to make the valid, inescapable point that by providing the Maryland Planned Parenthood affiliate with $540,000, we enable the same organization to spend $540,000 which it would not otherwise have on things outside of title X, including the performance of abortion, and that is our complaint.

I know you do not see it that way, but it is perfectly clear to me, and I do not see how anyone can escape that conclusion. You have every right under *Roe* versus *Wade* to perform abortions, to advocate abortions, to wallow in it to your heart's content, but the taxpayers are not obligated to subsidize that activity, and that is our point.

I think it is perfectly logical. That is the basis on which the Hyde amendment in another context has repeatedly been approved by both Houses of Congress, indeed upheld by the Court on a number of occasions in which the Court said women have the right to abortion, implying that others have the right to perform abortion, but the taxpayers are not obligated to subsidize the exercise of such rights.

We object to subsidizing the exercise of your right nationally and in Maryland to advocate for abortion, to refer for abortion, to perform abortion. It is just not right that taxpayers are being made to do that, and that is our gripe and our only gripe with you folks.

We are going to keep fighting and I think we will win because we are right and a great injustice is being done. We will rectify that in time just as we have Federal funding and subsidizing of abortion through Medicaid and the Indian Health Service and the Department of Defense, and the whole range.

We will succeed in the end, but in the meantime a great injustice is being perpetrated against the American people. I know you do not agree with that, but that is my statement.

I thank the Chair. I would be happy to hear a response, by the way, unlike other parties around here, not referring to the Chairman. I do not want this to be one-sided.

Mr. SWIRLING. I would like to respond, Senator, because I think it is not an inescapable fact. I think your conclusion is——

Senator MIKULSKI. Mr. Swirling, I would like you when you respond to Senator Humphrey, because I think this is an important point—to respond to my question to you, which is would title X be far less controversial if Congress prohibited the awarding of title X funds to agencies that openly advocate abortion?

Why do you not answer my question while you are answering his? I think this is the way good discussions go.

Mr. SWIRLING. Certainly. I do not think that the program would be any less controversial. In fact, I just think the program would not exist. The problem is that there is a thought process here that says if we do not give you one dollar, then you do not have it to spend and you therefore will not spend it on something else, and that is not quite the case.

What the title X program does is spend money to provide health care services to poor women, and there are many agencies in this country that get those moneys and they would not spend money on anything in that way because they just would not have the money for those services.

I am talking about hospitals, State and local health departments, independent clinics that are not affiliated with the Planned Parenthood Federation, and some Planned Parenthood affiliates as well.

It is not necessarily so that in Maryland $540,000 means $540,000 less in advocacy. It just means that Ms. Gurieva and her staff would have to decide where to make cuts, and where those cuts would be made would not only be, I would expect, just in advocacy, but maybe in advocacy, and would probably, though, be directly to the services to poor women.

So the program would not be less controversial because the program would not exist because people would not have the funds to spend on family planning services if high-quality, comprehensive health care, including what is required under medical ethics—the provision of information on all allowable options—is not provided.

Ethical practitioners cannot deny women who are pregnant with the information on all their options, and that is all that title X does. Title X does not fund abortions. If you took away the ability of physicians and other health practitioners to give that information, they would not accept the money. The title X program would not exist and 5 million poor women in this country would not receive planning family services at all.

Senator MIKULSKI. Ms. Gurieva, we have talked a lot about abortion. I would like to talk about adoption.

Ms. GURIEVA. Okay.

Senator MIKULSKI. Many people do not recall that I was a child welfare worker at Associated Catholic Charities, involved in foster care, residential care, and adoption. Adoption is a subject that is a very high priority with me in child welfare services.

The bill language has been very general and the report language dealt in some detail with adoption placement services. Could you discuss the feasibility of providing adoption placement services at family planning clinics?

Ms. GURIEVA. I think it is an interesting idea. I think it is an interesting concept and we have done some work at Planned Parenthood of Maryland looking at how we can enhance the work we do in relationship to adoption referrals.

We do what has been called here and we call everywhere options counseling, and we have women who come to us who want to carry their pregnancy to term and want to put their child up for adoption.

We are linked with a wide variety of referral sources, some of the same ones that you probably worked with at another stage. We have looked at ways in which we can try to enhance follow-up and try to enhance those services.

Whether family planning clinics should become the actual providers of adoption placement services is something that I am not sure about. In the same way that we do not use title X dollars to fund abortion, I would also question using title X dollars to fund adoption services. We really are a prevention program.

Senator MIKULSKI. So you see your primary mission as prevention and then when there are other services, to really refer them out to people who have a particular expertise in identifying appropriate families, making sure that the placement is appropriate, that the interest of the child is protected.

Would you say that family planning clinics have that expertise?

Ms. GURIEVA. I think some of them may have that expertise, but I am not sure that all of them—if you look at the wide scope of different kinds of settings in which family planning services are provided, I think some would have the expertise and some would not.

We have brought people from some of the various adoption programs in to do training for our counselors, for example, and if someone were to say would your counselors be qualified to do the kind of counseling that would be necessary to actually do adoption placements, I would have to say not without a whole lot more training.

But the issue is that if we can develop very strong referral programs where we can assure through follow-up that women get to the places that they are being referred, I am not sure that it is necessary because there are some very, very strong programs that have years of expertise in working with adoption.

I think at least our emphasis in Maryland has been on developing the linkages and the networks, not on developing the capacity ourselves.

Senator MIKULSKI. I see, but adoption is one of the options that is discussed.

Ms. GURIEVA. Absolutely.

Senator MIKULSKI. Well, I see the yellow light is going on and my time is concluded. If Senator Humphrey has any questions, we would be glad to submit them in writing. We are going to conclude this.

I would just like to wrap up this hearing by two comments, one a story and one a word of congratulations to each and every one of you, particularly those in front-line services, because I think you perform a very important community service.

But I would like to just close with what I call a tough love story. As a social worker, I left Catholic Charities because I wanted to deal with children before they had to go into foster care, and became a protective services worker at the Department of Public Welfare in child neglect and child abuse.

Twenty years later, having gone into politics, the day of my election I was in a community in which a woman walked up to me, beautifully dressed, and said, do you not remember me? I am Linda so-and-so, one of your old protective service constituents.

I said, yes, I remember you; how are you? And she said I am doing great, and she said I will never forget the time, she said, you scared the heck out of me when you said what do you want to do with your life. Do you want to change it? Do you want to think about yourself and your future?

She said, you laid it out. You were not one of those counseling types; you were one of those talking types. She said, but the day you got me into a training program and the day you told me about the Family Planning Program, it changed my life.

I am now married. My five children are raised; the last is in college. I now work for the Maryland Transit Authority. I now make $28,000 a year. My children are college graduates and I have got a different life because you saw me get into training and you helped me get a hold of my life in terms of not having any more children.

I just conclude with that because as we think about welfare reform, creating opportunities in our society, all we do is provide options and opportunities. There is no mandatory anything, but for that women her life was changed.

I will tell you, if that is the only thing I have done in my life, even including being a U.S. Senator, then I think my life has been a success.

[Additional material supplied for the record follows:]

American
Academy of
Pediatrics

141 Northwest Point Blvd.
P.O. Box 927
Elk Grove Village, IL 60009-0927
Phone (312) 228-5005

Reply to:
Richard M. Narkewicz, M.D.
Timber Lane Medical Center
81 Timber Lane
South Burlington, VT 05401
(802) 864-5011

President
William C. Montgomery, M.D.

Vice President
Richard M. Narkewicz, M.D.

Past President
Martin H. Smith, M.D.

Executive Director
James E. Strain, M.D.

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Little Neck, New York

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Miami Beach, Florida

Leonard P. Rome, M.D.
Shaker Heights, Ohio

Kenneth O. Johnson, M.D.
Milwaukee, Wisconsin

Betty A. Lowe, M.D.
Little Rock, Arkansas

Donald W. Schiff, M.D.
Littleton, Colorado

Birt Harvey, M.D.
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LaPlata, Argentina

July 31, 1987

The Honorable Edward Kennedy
United State Senate
Russell Senate Office Building
Washington, DC 20510

Dear Senator Kennedy:

On behalf of the American Academy of Pediatrics I appreciated the opportunity to present the Academy's view on the reauthorization of Title X Family Planning Program Services before you on July 30, 1987, in the Committee on Labor and Human Resources. That was a very informative meeting and I commend you on keeping the focus of the meeting on the family planning issues.

For matters of clarification, I would like to submit an additional statement in lieu of the questions and subsequent testimony so that your Committee is absolutely clear on the position of the American Academy of Pediatrics.

The Academy is opposed to mandatory parental notification for family planning services and is in favor of family planning services being allowed to discuss all three options for a pregnant client. That is continuing the pregnancy and keeping the child, continuing the pregnancy and relinquishing the infant for adoption, and having an abortion. To clarify this, I have included an additional statement.

I thank you for your interest and concern for children and adolescents and the Academy encourages you to continue your good work. Your staff is excellent, well organized and very thoughtful of the witnesses.

Best personal regards,

R. M. Narkewicz, M.D.

Richard M. Narkewicz, M.D.
President Elect
American Academy of Pediatrics

RMN/dlm

Enclosure

cc: William Montgomery, M.D.
Donald Schiff, M.D.
James Strain, M.D.

ADDITIONAL STATEMENT

FOR

TESTIMONY

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON

REAUTHORIZATION OF TITLE X FAMILY PLANNING SERVICES PROGRAM

PRESENTED BY

Richard M. Narkewicz, M.D., F.A.A.P.

President Elect

American Academy of Pediatrics

July 31, 1987

To clarify the Academy's position on two points, I wish to state the Academy's position on mandatory parental notification for family planning services and the Academy's position on counseling and referral for pregnant teenagers.

The Academy is opposed to mandatory parental notification for family planning services. It must be understood clearly at the outset that the Academy strongly favors and encourages parental involvement for adolescent care. There is no question that young persons are best served by the advice and guidance of caring parents. However, proposals requiring parental notification would do nothing to promote family participation. Parental involvement and communication cannot be mandated. Nor does routine notification, as an isolated response, constitute encouraging parental involvement. There is no question that serious decisions made in regards to family planning by teenagers could benefit by the experience, understanding and concern of a loving parent. We would strongly encourage this. However, the fact that this loving concern and counsel cannot be obtained should not stand in the way of adolescents being allowed to make these serious decisions.

The Academy concurs with the College of Obstetricians and Gynecologists that a prohibition on the content of counseling between the patient and her physician is contrary to medical standards and severely erodes the patients right to informed consent -- a fundamental priniciple of medical practice. This is not only

unnecessary governmental intrusion into the practice of medicine, it is simply bad medicine. All patients are entitled to the unbiased truth supplied by their physician or medical counselor and the ability to make a clearly informed consent for any type of medical therapy or treatment.

R M Narkewicz, M.D.

Richard M. Narkewicz, M.D.
President Elect
American Academy of Pediatrics

Honorable Edward M. Kennedy, Chairman
Honorable Orrin Hatch, Ranking Minority Member
Senate Labor and Human Resources Committee
ATTN: Hurdis Griffith, 527 Hart Senate Office Building
Washington, D.C. 20510

Thank you for inviting me to testify before your committee on S. 1366, the Title X Reauthorization bill. I had hoped to be there as a supporter of the bill, and to testify in opposition to a provision attached to last year's bill providing for a special demonstration project in Utah. As director of Planned Parenthood of Utah, the state's major Title X provider, I believe that the demonstration project would have been a step backward in our ongoing effort to reduce unwanted pregnancies among teenagers, by undermining the confidential services that Title X clinics are mandated to provide them. The demonstration project would have singled Utah out for separate treatment -- but unwanted teen pregnancy is not a Utah problem, it is a national problem requiring national solutions.

Having said that, I'm sorry I couldn't be there to discuss this issue with the committee. While Sen. Hatch and I disagree on some of these issues, I think we have a healthy mutual respect for each other, and both care deeply about the problem of adolescent pregnancy in Utah and across the country. Unfortunately, I am leaving Utah to become director of Planned Parenthood of Rhode Island, and I have made commitments in Providence that make it impossible for me to attend the hearing.

Sincerely,

Barbara Baldwin, Executive Director
Planned Parenthood of Utah

STATEMENT OF

JACQUELINE DARROCH FORREST

DIRECTOR OF RESEARCH

THE ALAN GUTTMACHER INSTITUTE

SUBMITTED TO THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

JULY 30, 1987

Mr. Chairman, I am Jacqueline Darroch Forrest, Director of Research for the Alan Guttmacher Institute (AGI), an independent, nonprofit corporation for research, policy analysis and public education on matters related to reproductive health and population. On behalf of AGI, I would like to express my appreciation for the opportunity to submit this statement pertaining to two matters relating to the reauthorization of Title X that we believe deserve your concerted attention, because they are important to men and women throughout the country, especially those of childbearing age: teenage pregnancy and contraceptive availability.

Teenage Pregnancy

A number of questions have arisen based on studies by Stan E. Weed and Joseph A. Olsen that allege that the net result of the provision of contraceptive services through publicly-supported family planning clinics over a ten-year period has been an increase in pregnancy rates among teenagers. Weed and Olsen claim that a state-by-state analysis of data from various sources shows that family planning programs had no beneficial effects on teen pregnancy rates.

The fact is, Mr. Chairman, that the number of adolescent pregnancies has actually decreased each year from 1980 through 1983, the last year for which data are available. A study by the federal government's Centers for Disease Control found a six percent decline between 1974 and 1980, from 204.5 per 1000 to 193. More recent statistics from the National Institute of Child Health and Human Development show a seven percent drop between 1974 and 1983.

In addition, Weed and Olsen's study fails to take into account several key factors, including the significant rise (by nearly two-thirds) in teenage sexual activity. Without increased use of contraceptives by sexually active

teens, the teen pregnancy rate might have been expected to rise sharply with the rise in sexual activity. Because teen pregnancy has decreased at the same time that teen sexual activity has increased, most researchers conclude that family planning services have played an important part in the management of teen pregnancy.

Moreover, there is no research that shows that the availability of contraception has any influence on teenagers' decisions to become - or not to become - sexually active. It is known, however, that 88 percent of teenagers who come to family planning clinics do so only after they have become sexually active, and most wait more than a year after first intercourse. If the availability of contraception encouraged young people to become sexually active, most teenagers would be expected to seek contraception before first intercourse.

Furthermore, Weed and Olsen's study only looked at the use of family planning clinics, and their relationship with teen pregnancy without noting that family planning clinics are but a small piece of the overall picture, which also includes the availability of contraceptives from private physicians, or over-the-counter in pharmacies. While clinics are only one among many types of providers, they are nonetheless an important source of services, especially for teens. Researchers at Johns Hopkins University found that unmarried teens using clinics were equally effective contraceptive users as those going to private physicians.

For your additional information, Mr. Chairman, I have attached a more formal response to some of the individual points raised by Weed and Olsen

which may help explain some of the other problems with his research (see Appendix 1).

Last year, I was fortunate to be part of a special panel on adolescent pregnancy convened by the National Academy of Sciences (NAS) which issued a report, "Risking the Future," based on an exhaustive two-year review of the wealth of research and information in the field. It is interesting to contrast the findings of the NAS report with that of Weed and Olsen's; although it made many recommendations, the report concluded that the surest strategy for preventing teen pregnancy was to encourage diligent contraceptive use among adolescents.

More specifically, looking at the year 1982, the NAS report offered the following insights into the scope of the teen pregnancy problem:

- Among the 9.77 million female adolescents aged 15-19 in that year, not quite half initiated intercourse;
- Of those that did, just less than half (1.86 million) used contraception and about 16 percent of this group became pregnant;
- Of the estimated two million who did not use contraception, about 30 percent became pregnant;
- Of the estimated 897,000 premarital pregnancies in that year, about 39 percent (348,000) ended in abortion, 12 percent (104,000) ended in miscarriage, and just under half (445,000) resulted in live births;
- Of these premarital conceived births, approximately 184,000 were legitimated by marriage and roughly 261,000 ended in out-of-wedlock births;

- Of the women with nonmarital births, only a very small proportion placed their infants for adoption and about 249,000 became single parents.

The report emphasized that teens who carry unintended pregnancies to term and become parents are at serious risk of health and nutritional deficiencies, school dropout, unemployment, single parenthood, poverty and long-term welfare dependence. And although unmarried teenage parents are a small proportion of the entire adolescent population, their problems and needs entail high public costs. Thus, the NAS panel stated that its top priority is to "reduce the rate and incidence of unintended pregnancy among adolescents, especially among school-age teenagers."

The panel examined many types of programs intended to address this goal, and it found that only three were able to document pregnancy reductions: contraceptive services provided through two specific school-based and school-linked health clinics and one after-school program. While the report found that sex education does not affect the probability of initiating sexual activity, it also concluded that there is insufficient evaluation research to judge with certainty the effects of such programs on contraceptive use and pregnancy. It found programs directed at improving family communications effective at increasing parent-child discussions in the short run but was unable to conclude that these gains last or that they have an impact on teen pregnancy.

The panel had no trouble, however, in concluding "that the major strategy for reducing early unintended pregnancy must be the encouragement of diligent contraceptive use by all sexually-active teenagers." In examining

the effectiveness of contraception, the panel found that clinics and private physicians are equally effective providers, although it noted that teens often gravitate toward clinics because of their concerns about confidentiality and cost. It found no evidence that the availability of contraceptive services causes higher rates of adolescent sexual activity, unintended pregnancy, abortion or births to unmarried teenagers, as critics of family planning services have suggested.

The group concluded that the risks associated with contraception for adolescents are extremely low. It found that for young people who do not smoke, the pill carries a lower risk of death than any other method, except barrier methods backed up by abortion of contraception fails. Moreover, the pill provides protection against several health risks including benign breast disease, uterine and endometrial cancers, ectopic pregnancy and ovarian retention cysts. The panel also stressed the importance of condoms as a readily accessible contraceptive that not only prevents pregnancy but also protects against sexually transmitted diseases, noting that some innovative condom distribution programs have been undertaken, including making condoms available not only in pharmacies and clinics but also in recreation centers, pool halls, union halls, barber shops, restaurants, bars and gas stations.

The panel found encouraging evidence on the efficacy of school-based and school-linked health clinics. It cited data from the St. Paul, Minnesota school-based clinic program showing declines in the student birthrate from 79 per thousand in 1973 to 26 per thousand ten years later; and data from

Baltimore showing a 26 percent decline in pregnancies over a three-year period in a school-linked program while pregnancies in a control group increased dramatically.

The panel noted that while contraceptives undoubtedly work, they are essentially useless if young people are not sufficiently motivated to avoid pregnancy, and emphasized that preventive approaches to teenage pregnancy are far and away the most cost effective, with estimated annual costs ranging from $10 per participant for sex education to $125 for comprehensive school-based health clinics.

"There are no easy answers or quick fixes" to the problems of teen pregnancy and childbearing, says the NAS report. And the nation has been unable to develop a coherent policy because there is no agreement on the nature of the problem itself - sexual activity, pregnancy, abortion or childbearing. Recognizing this disagreement as well as the diverse needs of different adolescents, the panel proposed several strategies and specific interventions.

After conducting an exhaustive review of the literature, the panel concluded, however, that the most effective intervention for reducing unintended pregnancy is contraception, and it urged continued support for a variety of contraceptive service models, including private physicians. Contraceptive services, it argued, should be provided free or at low cost, and existing public programs such as Title X and Medicaid must continue to support contraceptive care for adolescents, minimizing barriers of cost, convenience and confidentiality. The panel found that the pill is the safest and most effective means of birth control for sexually active adolescents, and it

advised "aggressive public education" to dispel myths about the health risks of pill use. It also recommended the development, implementation and evaluation of condom distribution programs; the development, refinement and evaluation of school-based clinics; and the inclusion of information about contraception in sex education programs. Finally, it suggested the use of paid promotional advertising of contraceptives, accompanied by an evaluation of its effects on contraceptive use and unintended pregnancy. For your further information, Mr. Chairman, I have attached a summary of the NAS report (see Appendix 2).

Contraceptive Research and Availability

I would now like to turn to the issue of contraceptive availability - or the lack thereof - in the United States. Let me suggest, Mr. Chairman, that increasing the availability and effective use of contraceptives by American couples could — and should — be linchpins in our attempts to confront and arrest two haunting social problems: unacceptably high rates of infant mortality in the United States and high rates of abortion. While these two issues are not often spoken of in the same breath, because their politics are perceived to be quite different, they are, in fact, closely related; both problems could be alleviated in large measure by helping American couples avoid unintended and mistimed pregnancies.

In 1980, Mr. Chairman, the U.S. Surgeon General set a national goal of reducing infant mortality rates among minorities and low-income women by almost half by the end of this decade. However, in a "Midcourse Review," released only a few months ago, Dr. Koop concluded that the nation will not

meet its goal by 1990 - possibly not even until the end of this century. As you certainly know, Mr. Chairman, low birthweight is the major factor associated with the death of infants in the first four weeks of life. As a society, one thing we clearly must do to address this problem is to provide access to high quality prenatal care for all expectant mothers in our country. At the same time, we must note that, according to a major report by the Institute of Medicine (IOM), the first step in reducing both low birthweight and the resulting high infant mortality rates is the prevention of unintended pregnancies to "high risk" women. These women include teenagers, women who have only short intervals between pregnancy, women of low socioeconomic status, women with lower levels of education, and those who are unmarried. Among the IOM's specific recommendations was increased access to family planning services, with special emphasis on reaching low-income women and unmarried teenagers under 18. The report specifically emphasized the importance of the federal Title X family planning program in accomplishing this objective.

At the same time, Mr. Chairman, reducing rates of unintended pregnancy through better contraceptive use clearly will also help decrease levels of abortion in the United States, among both teenagers and adult women.

It seems clear that better contraceptive use should be able to make major inroads towards ameliorating both the very serious societal problem of infant mortality and equally serious -- and politically explosive issue of unintended pregnancies and abortion. However, no such strides can be made unless contraceptives are both available and effectively used. It has been well established that contraceptive prevalence and consistent use are higher

where there is a greater selection of contraceptive methods. Yet, for a plethora of reasons, the shocking fact is that U.S. women and men are in the unique if uneviable position of losing contraceptive options at the same time that new methods are being regularly introduced around the world.

Studies conducted by the Alan Guttmacher Institute have revealed a range of obstacles currently facing contraceptive research, development and marketing in this country, and with your permission, Mr. Chairman, I will submit for the record two articles published in Family Planning Perspectives, which summarize the results of those studies (see Appendix 3). These obstacles may be daunting, but hopefully not insurmountable. Prominent among them are insufficient and unstable funding, which has declined worldwide by about 25 percent in real dollars since the mid-1970s; the high cost of liability insurance for contraceptive products, which together with the virtual impossibility of obtaining insurance for clinical tests on humans, is leading to a near-paralysis of research into new methods; and the complex premarketing requirements and regulatory procedures of the FDA which delay approval of many methods for use in the United States. Not surprisingly, only one private U.S. pharmaceutical company remains in the business of conducting contraceptive research and development directed towards the U.S. market.

While no single entity, including the U.S. government, can solve this problem in its entirety, the problem will only grow worse if it is not addressed. Mr. Chairman, you and your committee possess one key - by authorizing the increase of both the amount and the stability of government funding for research leading to contraceptive development, through the special contraceptive development initiative contained in S. 1366, you open the door

for new methods that will be safer, more effective and more accessible to the individuals who need them most. At the same time, continued government efforts to evaluate the safety and efficacy of methods now in use also are critical. Such government research can be critically important in debunking myths surrounding certain methods -- particularly the birth control pill -- that still are pervasive in our society. Accurately altering people's erroneous perceptions of the health risks and benefits of certain contraceptives can lead to better use by allowing Americans to take full advantage of the few options still available to them.

Recognizing the need to accelerate the development of new contraceptive methods, and to ensure the continued safety and efficacy of existing ones, the National Institute of Child Health and Human Development (NICHD) designed a Contraceptive Development Initiative some two years ago. While the initiative has produced some progress in a few areas, it is clear that it has not been able to meet its full potential due to lack of adequate funds. Accordingly, we commend to the committee's consideration an additional $10 million in FY 1988 funding for NICHD through the Title X program, directed specifically toward the initiative in S. 1366. There can be little doubt of such an initiative's cost-effectiveness in both human and economic terms over the long run.

Thank you.

(Note: In the interest of economy, the appendix material accompanying this statement was retained in the files of the committee.)

Senator MIKULSKI. The committee is adjourned.
[Whereupon, at 5:25 p.m., the committee was adjourned.]

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